EXPLORATION OF CULTURAL COMPETENCE IN AN UNDERGRADUATE PHYSIOTHERAPY PROGRAMME

By

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ABSTRACT

Conflicting definitions, understanding and consequent limitations in identifying an appropriate body of knowledge present a major problem for educators who wish to define, adopt and teach cultural competence. A standardised meaning of the term enabling specified outcome measures to be identified could assist effective translation and evaluation of its contribution in developing professionalism in undergraduate health care education. In attempting to seek clarity, perception and relevance of cultural competence in a professional undergraduate programme, a review of the literature and a mixed methods case study of a cohort of 63 undergraduate physiotherapists were undertaken. Constructs of cultural competence were elicited using repertory grids and meanings explored with the use of questionnaires, interviews and evaluation in the teaching and learning of the topic.

Results gave new insight into undergraduate physiotherapists' perception of cultural competence vis-à-vis their clinical competence. Interpretations of perception and expressions of cultural competence varied throughout the literature but, despite this, specific learning and resource needs of students studying the topic were identified.

Implications of cultural competence in developing professionalism within health care education were highlighted and evaluated. The need for further research into teaching and learning of the topic in physiotherapy education is supported by the study.

DEDICATION

This thesis is dedicated to my husband

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This thesis is the result of a multitude of inputs at many levels but I wish to acknowledge the supreme efforts of my supervisor Professor Alison Bullock, who was a bedrock of support and Dr Natasha McNab, and the School of Education at Birmingham University for its academic input.

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My students and patients have always been a motivating force in my life so it is to them, especially to the students who undertook this journey with me, to whom I would also like to make a special tribute. Thank you also for allowing me to join you as a learner.

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

GLOSSARY OF TERMS

Abbreviations used within the thesis

AHP	Allied Health Professions/Professionals
AMSA	American Medical Student Association
APTA	American Physical Therapy Association
BICCC	Blueprint for Integration of Cultural Competence in the Curriculum
BSc	Bachelor of Science
CASQ	Cultural Awareness and Sensitivity Questionnaire
CCCHS	Caffrey Cultural Competence in Health Care Scale
CLAS	Culturally and Linguistically Appropriate Services
CPD	Continuing Professional Development
CSP	Chartered Society of Physiotherapy
DBIS	Department of Business and Innovation and Skills
DH	Department of Health
FHEQ	Framework for Higher Education Qualifications
HE	Higher Education
HPC	Health Professionals Council
HRSA	Health Resources and Services Administration
IAN	Interface of Anthropology and Nursing
IAPCC	Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals
IAPCC-R	Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals-Revised

IBR	Illness, Behaviour and Research
ICC	Integrated Cultural Competence
ICC Plus	Integrated Cultural Competence Plus
JSNA	Joint Strategic Needs Assessment
KSF	Knowledge and Skills Framework
LA	Local Authority
LEARN	Learn, Elicit, Assess, Recommend, Negotiate
MEGs	Minority ethnic groups
NCCC	National Centre for Cultural Competence
NHMRC	National Health and Medical Research Council
NHS	National Health Service
OMH	Office for Minority Health
PCT	Primary Care Trust
QT1	Questionnaire Time 1
QAA	Quality Assurance Agency
QT2	Questionnaire Time 2
RG	Repertory Grid
RNAO	Registered Nurses Association of Ontario
SfH	Skills for Health
SHA	Strategic Health Authority
SWOT	Strengths Weaknesses Opportunities and Threats
TACCT	Tool for Assessing Cultural Competency Training
UK	United Kingdom
UNESCO	United Nations Educational, Scientific and Cultural Organisation
US	United States

USHHSOMH	United States Department of Health and Human Services Office of Minority Health

CHAPTER 1 INTRODUCTION

1.1 Cultural competence and undergraduate physiotherapy education

Literature investigating cultural competence in physiotherapy education within the United Kingdom (UK) is minimal and, despite growing interest, the topic has remained relatively unexplored by developers of curricula in health care (Norris and Allotey, 2008; Stewart, 2002). Furthermore, little is known about how the topic is perceived by members of the profession. Proponents for its inclusion in curricula have been varied but Bentley et al (2008) have identified that, within the UK, the training of all major health care professionals in cultural diversity, including physiotherapy, is inadequate. Similarly, a Cochrane Review conducted in 2007 concluded that the development plans for a healthy work environment in health care settings should include skills needed to deliver cultural competence in health care organisations (Pearson et al, 2007).

Little consensus exists between the governing bodies, regulators of the professions, and professional bodies on what constitutes a satisfactory syllabus for the topic. There are no national guidelines to incorporate cultural competency in the training of UK health care professionals (Bentley et al, 2008). Therefore, the learning and teaching of the topic is interpreted at local levels and is often integrated into other topics making the visibility of the content and learning outcomes inconsistent or invisible. Physiotherapy education is governed by two of the largest UK governmental departments – the Department of Health (DH) and the Department for Business, Innovation and Skills (DBIS), while regulation and

delivery of physiotherapy practice and education is undertaken on their behalf by the Health Professions Council (HPC) and the universities. There is no consistency in statutory, professional or educational demands from these bodies for the inclusion of cultural competence in undergraduate physiotherapy education.

Reasons for contemplating more visible inclusion of the topic in undergraduate physiotherapy education, including how the topic is perceived by its undergraduates, have been influenced by a number of factors. Global movement of communities around the world and their relocation within countries including the UK has added to the diverse range of people whose health care needs require practitioners to have a range of communication and culturally appropriate skills in order to deliver effective care. Diverse populations present variations in age, ethnicity, disability, sexual orientation and religion and may be categorised subjectively and objectively in other ways. Recognition of and respect for multiple diversities are increasingly being demonstrated in the policies and procedures of the DH and have been for the last decade. Their impact in transforming the skills and approaches of health care practitioners, including those of physiotherapists, in adapting has not kept pace with this change (Norris and Allotey, 2008; Dogra, 2005; Jaggi and Bithell, 1995). The stimulus to examine practice and to establish how effective care for increasingly diverse populations is is a challenge for all professions including physiotherapy (Norris and Allotey, 2008).

The DH, universities and developers of curricula aim to produce graduates who are ‘fit for purpose’ i.e. practitioners who are able to address the needs of the

patient, listen, engage communities, ensure public-user involvement and to adopt approaches which bring the practitioner closer to improved personalised care (DH, 2009). Yet, the research evidence continues to show that the quality of health care for minority communities in a number of areas, for example, cancer, stroke and mental health, is inferior to that for white Caucasians (Bennett and Keating, 2009; Smith et al, 2009; Papadopoulos et al, 2008; Bhui et al, 2007). Questions have also been raised related to the attainment of relevant knowledge, skills and competencies required by health care professionals when judging their ability to engage with clients from diverse backgrounds and how they might close the communication gap between themselves and their clients (O'Shaughnessy and Tilki, 2007; Bentley et al, 2008). Desirable skills aimed at addressing some of these inequities of care are major features of cultural competence (Campinha-Bacote, 2003). Curricula for health care practitioners which include cultural competency skills have been forwarded as a means of addressing some of the issues that have been raised (Bentley et al, 2008; Capell et al, 2008).

On graduation, physiotherapists are expected to be competent in core skills including assessment, clinical reasoning, goal setting, communication and manual skills and treatment evaluation as outlined within the Chartered Society of Physiotherapists (CSP) Curriculum Framework (CSP, 2002), which has been recently revised to become The Learning and Development Principles for CSP Accreditation of Qualifying Programmes in Physiotherapy (CSP, 2011a). These learning and development principles highlight the requirements for graduates to demonstrate and further develop transferrable skills where communication, inter-

professional collaboration and continuing professional development are appropriate to an evolving National Health Service (NHS) and demographic changes within the population. The development of intercultural communication and cultural competence in undergraduate physiotherapists would seem to form a natural part of this process. Similar thoughts have been expressed by Kelly and Papadopoulos (2009), O'Shaughnessy and Tilki (2007) and Rogers-Sirin and Sirin (2009) who share the view that cultural competence needs to be incorporated into the training of health professionals in general.

Although, the HPC requirements for physiotherapy qualifying programmes are that equality and diversity are addressed within the curriculum, there appears to be limited reference to the term cultural competence within these requirements. The degree of inconsistency across undergraduate qualifying programmes within the UK, in relation to how skills in cultural competency or the development of similar skills in equality and diversity are developed and evaluated, could be influential in fuelling inconsistencies in graduate abilities with consequent inconsistencies in care for users of health care services. The CSP, as the professional body for the fifty thousand registered physiotherapists within the UK, has overall charge for developing, coordinating and disseminating a curriculum framework for undergraduate physiotherapy yet, its message on the topic is unclear. In its publication ‘Competence and Capability Resource Pack’ (CSP, 2007), it identifies cultural competence as a ‘facet of overall professional competence’ and as such offers practitioners ways in which it might be incorporated into practice, but the level to which successful implementation and outcomes might be assessed and

measured are not apparent. Both the HPC and CSP are highly influential national bodies who could profoundly shape how the topic is developed, taught and evaluated should they offer more focused guidance.

Investigations into the cultural competence of undergraduates in the Allied Health Professions (AHPs) within the UK have been limited in number and scope. Within physiotherapy useful contributions have been offered by O'Shaughnessy and Tilki (2007), Ratima and Waetford (2006), Main et al (2006) and Stewart (2002), and in occupational therapy, by Capell et al (2008), Suarez-Balcazar and Rodakowski (2007), Kale and Hong (2007), Trentham et al (2007) and Cheung et al (2002). However, difficulties arise when attempts are made to explore investigations because, instead of adopting the term cultural competence, other terms such as race, culture, diversity, cultural sensitivity, equality, equal opportunity and widening participation are used within the documentation and are often used interchangeably with a loss of clarity in the meaning attached to them. These factors contribute to difficulties in evaluating the student experience and expected learning outcomes of learning events. Definitions have been forwarded that continue to highlight the lack of consensus across organisations. A commonly quoted definition comes from Cross et al (1989). They state that it is

> .....a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al, 1989, p.13).

The National Centre for Cultural Competence at Georgetown University aligns cultural competence with Davis's (1997) definition, which suggests that it

integrates and transforms knowledge about individuals and groups of people into specific standards, policies, practices and attitudes which are appropriate in different cultural settings in order to increase the quality of their health care. Davis (1997) confirmed the idea of cultural competence as effectively operating in different cultural contexts, highlighting that knowledge, sensitivity and awareness do not include this concept and that it goes beyond mere awareness or sensitivity. Whilst Cross and Hicks (1997) emphasised cultural competence as effective working across systems and agencies, Davis (1997) picked up this theme of identifying quality of care and integration, and transformation of knowledge as the starting point and added the production of improved outcomes as central in the competence. Campinha-Bacote (2008) outlined it as encompassing desire, knowledge, awareness and encounter while Reynolds and Leininger (1993) suggest, that within it, cultural blindness, culture shock, culture imposition, ethnocentrism and cultural relativism may be barriers to developing knowledge about the culture of others.

Giger and Davidhizar (1999) highlight culture, ethnicity and religion as important elements, Purnell and Paulunka (2008) describes a developmental, conscious, non-linear process, while Ramsden (2000) emphasises cultural safety. Gerrish and Papadopoulos (1999) and Papadopoulos et al (2004) relate its significance in education and research. These contributions offer a number of approaches in understanding and developing cultural competence and demonstrate that perhaps development of the cultural competence of physiotherapists has been less defined and recognised than in other areas of heath care practice, especially nursing.

However, given that many of these approaches highlight the importance of the context in which cultural competence is developed, their application in addressing the learning needs of undergraduate physiotherapists may be limited and may require further contextual analysis in order to see how best cultural competence might be developed within the profession.

1.2 Professional skills and the cultural competence of physiotherapists

Identification of specific professional skills within physiotherapy continues to challenge analysts who seek to define the profession (Richardson, 1999). Profession-specific skills centred on exercise or movement, massage and manipulative skills are said to lie at the heart and origins of physiotherapy (Barclay, 1994). It has been said that for a long time physiotherapists have largely ignored the psychological, social and cultural dimensions of health and illness, in preference to a biomechanical view of the body, and that the time has come to redress this balance (Nicholls and Gibson, 2010).

The task of incorporating cultural competence within undergraduate physiotherapy lies not only in what topics are taught and how they are taught i.e. the curriculum, but of necessity requires investigation of the individuals involved in its delivery. In terms of age and ethnicity, the relatively unchanging profile of the face of the physiotherapy profession has been noticed. Boylan and Grant (2004) state that there are compelling moral and practical reasons why the membership of a profession should mirror the population that they serve. Over a long period, the average profile of a Chartered Physiotherapist remains that of a white, middle

class young female (Bithell, 2007). While other data classification on religion, sexual orientation and disability have been made less overt, Mason and Sparkes (2002) also confirm that young white females continue to form the bulk of the Society's membership. In an increasingly diverse society where the profile of the population is often strikingly different to the profile of the health care practitioners facilitating and offering them care, discussions prevail regarding the effect of these differences on relationships and on the level of communication which exists when caring for diverse and 'hard to reach' communities (Dogra et al, 2009; Foldy, 2003).

Until recently, limited records other than anecdotal evidence were found regarding the prevailing perceptions of cultural competence amongst undergraduate and practising physiotherapists. Not surprisingly, there are also limited records in the annals of the profession. In her book 'In Good Hands – A History of the Chartered Society of Physiotherapy 1894-1994', Barclay (1994) offers no view into issues of diversity and cultural competence within the profession but identified that in 1921 the gender imbalance of registered members was in a ratio of 12:1, women: men and that blind and visually impaired members were registered into the profession as early as 1895 (Barclay, 1994). There has been minimal development in furthering the exploration of perception of cultural competence within the physiotherapy profession, and the views of its members on the topic have rarely been exposed. Its exploration in physiotherapy undergraduates has the potential to assist in identifying how it is viewed by future practitioners, how the topic is learned and taught and offers a basis on which to consider its wider ramifications.

The workplace informing undergraduate curricula

Workplace guidance on how cultural competence is addressed through policies and procedures by qualified staff would seem to be as equally haphazard as the remit in undergraduate education, but there appears to be more consistency in policies and procedures to address issues of equality and diversity, practices with which it is commonly associated. However, if attempts are made to assess implementation of cultural competence through the Knowledge and Skills Framework (KSF), a central tool which is aimed at shaping and managing the learning of all staff within the NHS, other issues arise. The KSF offers opportunity for senior managers to assess, manage and evaluate incorporation of skills such as cultural competence in the workplace, but it is evident that this framework has been adopted to varying degrees within the NHS. This is despite it being a requirement for training in equality and diversity (Knowledge and Skills Framework (DH, 2004)), and that staff demonstrate competence in this area. It would seem that if the workplace gives cursory or at best inconsistent attention to the development of cultural competence, then it leaves developers of curricula the task of assessing and agreeing a strategy for its incorporation in undergraduate education.

Existing models of cultural competence in physical therapy education

Although the development of models for physiotherapy education has been slow within the UK, physical therapy, its counterpart in the US, has made greater strides. To inform the development, and to a more limited extent the measurement, of cultural competence in physical therapy, the American Physical

Therapy Association (APTA) employed a task force to develop a cultural competence curriculum APTA (2008). Tools employed included, a conceptual framework based on the theoretical constructs of Cross et al (1989) 'Towards a culturally competent system of care', Volume 1 and Campinha-Bacote's model 'The Process of Cultural Competence in the Delivery of Healthcare' (Campinha-Bacote, 2007). The view of cultural competence as progressing along a continuum that enhances knowledge, skills and attitudes and as a process of 'becoming' was the approach adopted. However, the holistic model of cultural competence presented by the APTA (2008) for adoption appears to make the assumption that educators delivering the programme will be competent. Although this approach offers a basis for considering how the topic might be learned and taught, a potential stumbling block could be in this assumption if, as O'Shaughnessy and Tilki (2007) identified, many staff feel ill-equipped to deal with the topic.

The US Department of Health and Human Services Office of Minority Health (USHHSOMH) has also released the influential document, 'Culturally and Linguistically Appropriate Services' (CLAS) which addressed three main components for enhancing cultural competence through organisations and individuals (USHHSOMH, 2012). Whilst it is acknowledged that this is a seminal work, the extent to which it might be translated, implemented and interpreted into a different social context such as the UK may be limited. Moreover, although there is potential to pattern a similar approach within the UK, a comparable governmental approach would need to be adopted.

The extent of the development of models which incorporate cultural competence into undergraduate physiotherapy education is unknown but as was alluded to earlier, the context in which learning and teaching of cultural competence takes place needs to be given careful consideration. Therefore, if other models were to be adopted, their integration and alignment with existing programmes would require appropriate adjustments in curricula (Lie, 2009).

1.3 Background to the study

A platform was established for the start of this research following the publication of the preliminary results of an Interim Report on 'Developing and evaluating educational and training programmes to increase cultural sensitivity of health care professionals to promote positive health outcomes' from the Nexus Project (Clifford et al, 1999). In the study conducted by Clifford et al (1999), concerns were raised by undergraduates and staff alike regarding their self-assessed level of cultural sensitivity. I was one of the four investigators involved in that study. Results in the report suggested that there was a need to move nursing and physiotherapy curricula forward on the issue of cultural sensitivity and that teaching should be adjusted to address the deficits noted. In attempting to address identified aims, my attention was further drawn to the suggestion in the report that the topic of culture and multiculturalism should not be an add-on but that it should fall within the mainstream of curricula (Clifford et al, 1999). This was influential in the action research approach adopted at the start of the investigations.

A search of the literature at that time also revealed that there was very little research and exploration of cultural competence in physiotherapy education and limited guidance existed for its incorporation into physiotherapy practice. A written submission was made by me to the relevant Curriculum Development Committee identifying possible changes which could potentially be incorporated within the curriculum for students in year one of the BSc (Hons) Physiotherapy course (see Appendix 1). In conjunction with the module planning team, permission was given to make appropriate adjustments in the teaching of two modules in order to achieve the learning outcomes of the topics and to address certain recommendations specified in the Report. Further suggestions for changes to the programme as a whole as outlined in the Interim Report were also discussed with the team but further changes were left for future action.

1.4 Aims of the research

The aim of the research was to explore perceptions of cultural competence in undergraduate physiotherapists in order to inform ways of implementing its learning and teaching in undergraduate physiotherapy education.

In conducting this study, the following steps were undertaken:

- Exploration and critical analysis of cultural competence in relation to physiotherapy
- Investigation of the perceptions of cultural competence held by undergraduate physiotherapists

- Investigation and identification of the learning needs of undergraduate physiotherapy students in cultural competence
- Evaluation of the outcomes of the investigations and implications for teaching and learning
- Identification of possible areas for future research.

In operationalising the research, the investigations sought to answer specific questions:

How does cultural competence present within physiotherapy?
How do undergraduate physiotherapists perceive cultural competence and what are the implications for learning and teaching the topic?

1.5 Structure of the thesis

Following the introduction, Chapter two offers perspectives of cultural competence including definitions and models. Cultural competence is explored in learning and teaching in health care generally, and more specifically in physiotherapy looking at its perception in undergraduate education. An in-depth analysis of associated terms and themes within the literature to assist in understanding the context of its development is then offered. The relationship of cultural competence to the development of professionalism in physiotherapy is examined and related learning and teaching theories which address the needs of these undergraduates as adult learners are evaluated. The chapter also discusses the purpose and significance of the study. Chapter three offers discussions on methodology and the mixed

methods case study approach, and how it evolved. Chapter four introduces the researcher, the subjects and addresses the ethical implications of the study. The case study is then presented chronologically and investigations, findings and related discussions are offered in the relevant chapters: Chapter five addresses year one; Chapter six, year two and Chapter seven presents developments in year three. Overall evaluation and triangulation of the data are presented in Chapter eight. Chapter nine discusses undergraduate physiotherapy students' perceptions of cultural competence, associated learning and teaching needs, influences and implications in curricula and addresses fundamental questions relating the topic to developing professionalism in physiotherapy. It identifies the scope for further research and potential for developments of the topic in health care generally. Reflexive accounts are offered at different points throughout the investigations. The study concludes in Chapter 10 by assembling pertinent points arising from the overall study.

CHAPTER 2 LITERATURE REVIEW

This literature review is divided into a number of topics. Exploring the term ‘cultural competence’ and contextual understanding, it traces its historical development and considers it from national and international perspectives. It considers a number of associated definitions and their significance to the study including identified models. The topic which then follows assesses the position and perspective of cultural competence in learning and teaching in physiotherapy and health care education. Associated terms from the literature are explored with reference to their implications in learning and teaching the topic. Finally, issues of measurement and evaluation of the significance of cultural competence as part of developing professionalism in physiotherapy undergraduates are examined.

Searching the literature continued over the lifetime of the study and was approached in a number of ways. Access to numerous databases including CINAHL, AMED, Medline, British Nursing Index and Cochrane in search of journal articles and other relevant material was conducted. Search strategies adopted terms and their variations including cultural competence, cultural sensitivity, cultural care, cultural awareness, transcultural care and intercultural communication. Where possible, policy documents, public and private records, theses and conference papers were accessed electronically or manually. Primary sources such as letters and documents were accessed through private written communications to relevant individuals such as Dr Josephina Campinha-Bacote.

Tertiary sources such as guidebooks and handbooks were obtained through the University and private communications.

2.1 Exploring cultural competence

A plethora of literature adopting the term cultural competence became evident by the mid-1990s and 2000s where further attempts were being made to recognise and respond to the growing health needs, cultural practices and the expectations of increasingly diverse communities. The writings of Thorpe and Baker (1995), Wells (1995), Leininger and McFarland (2002), Campinha-Bacote (2007) and Papadopoulos et al (2008) amongst others have documented evidence of approaches and strategies which were being contemplated and attempted. More specifically, in relation to race, ethnicity and class, and mental health nursing, the term cultural competence was increasingly used to address the disparities (Brach and Fraserirector, 2000; DelVecchio Good et al, 2003). In the US, use of the term grew at a pace and most notably following publication of the Institute of Medicine's report on 'Unequal Treatment' (Smedley et al, 2003).

In the ensuing years, cultural competence has developed its own momentum and it has become increasingly evident that its definition, practice, measurement and conceptual mapping have presented researchers with a myriad of confusing and at times, conflicting dialogues. Lack of conceptual clarity and rigour (Lo and Stacey, 2008) and the prevailing cloudiness in the messages associated with its use with terms such as cultural sensitivity, equality and diversity have been cited by Capell (Capell et al, 2008). Within the UK, understanding and application of the term cultural competence in higher education (HE) is strongly associated with issues

relating to ‘equality and diversity’. An internet search of the two terms on the Higher Education Academy website in 2010 investigation showed that the term cultural competence was far less pervasive in the courses, structures and functions of the Academy than the term ‘equality and diversity’.

This reinforces the challenge posed by the London Deanery (2009) to establish the meaning of the term and methods to identify and engage leading training providers and thought leaders. Following lengthy investigations of the literature, interviews with leading academics and through different levels of engagement with Trusts and stakeholders, the conclusion reached by the Deanery was that there was no universally accepted definition of the term within health care settings and in education within the UK. As stated by the Deanery, the relationship between the two terms ‘cultural competence’ and the more commonly adopted term ‘diversity’, was related to the extent to which individuals engage and learn, become flexible, use responsive styles, and show empathy and engagement in the clinical situations they encounter. Therefore, the suggestions forwarded by them include adoption of the term nationally and for strategies to explore the relevant issues highlighted in its report. The call is for a national approach similar to the one which has been adopted by the Australian Government (NHMR, 2006). Evidence points to the fact that within the UK, government, higher education establishments and other public bodies at varying levels of management and practice have adopted the term cultural competence without recognising a universally held definition (Bhui et al, 2007). The abundance of varying definitions and views are reflected in

international literature and consequently, in undergraduate health care programmes such as physiotherapy (Srivastava, 2007).

Perspectives of cultural competence

The widespread use of ‘cultural competence’ as a concept is evident in the health care literature emerging from the US, Canada, Australia and New Zealand, and Europe. In the US, the perspective appears to be dominated by race and ethnicity. Health Resources Services Administration (HRSA), Bureau of Health Professionals identifies cultural competence as knowledge-based skills required to provide effective clinical care to clients from a particular ethnic or racial group. It could be argued that this is a very narrow definition since it takes a limited account of certain groups of people not contained in the definition. On the other hand, it could be viewed as all inclusive if ethnic groups are seen as all-encompassing i.e. majority and minority ethnic. It also reinforces grouping everyone into an ethnic or racial category and assumes ‘race’ to be an appropriate categorisation of people.

Debates currently amongst geneticists and anthropologists would contend that race is a social construct (American Anthropological Association, 1998) and there is often failure to report how race and ethnicity were determined in published research reports (Salway et al, 2009; Shanawani et al, 2006) which questions the reliability and validity of some of the findings. Despite this, in health care, the US has been at the forefront in promoting inclusive and comprehensive definitions of cultural competence. The USHHSOMH and its educational departments have launched several programmes where cultural competence has been central in the

operation of its policies. For example, the National Centre for Cultural Competence (NCCC), US Office of Minority Health (OMH), American Medical Student Association (AMSA) and the American Physical Therapy Association (APTA) have embedded the terminology and its practice into health care over a long period of time.

In Canada, the Registered Nurses' Association of Ontario (RNAO) in association with Health Canada and Office of Nursing Policy concluded that in health care while diversity is an ideology, cultural competence is a skill and that by embracing cultural diversity, there was a commitment to pursue culturally competent practices (RNAO, 2007). This important differentiation between ideology and skill has not been made as explicit in health care literature published elsewhere and it makes an important contribution to discussions on the topic.

Work conducted in New Zealand and Australia has added little clarification in the international confusion in defining cultural competence as a concept and how it pertains to health and health care. In New Zealand, Main et al (2006) state that cultural competence in physiotherapy includes practising in a culturally safe manner. The preferred term forwarded is 'cultural safety' where it is reasoned that cultural safety extends the debate beyond issues of diversity to include how people are described, how practitioners understand themselves and how they are viewed by receivers of their care. It puts the client as the assessor of the level of competent care. The development of the concept of cultural safety in New Zealand has been strongly influenced by the Treaty of Waitangi and treatment of the Maori

people hence the context had a major impact on how it developed and is practised. Attempts to place user perspective at the heart of practice are often limited by some of the approaches adopted and the use of ‘cultural safety’ attempts to address this.

The Australian Government’s National Health and Medical Research Council (NHMRC, 2006) has identified the need to increase cultural competency in health as a priority and in so doing has published its guide which places the concept of ‘reciprocity’ at its heart. It claims that viewing cultural competence from four perspectives; the systemic, organisational, professional and individual, and applying policy nationally, increases the robustness and offers improved focus on the topic. This model is at variance with a number of the previous educational models, in that it proposes that cultural knowledge should be institutionalised in order for systems to become more culturally competent. This approach appears to facilitate consensus around a common understanding and focus on the topic for health care practice which evidence suggests is lacking within the UK.

On a wider international scale, The United Nations Educational and Scientific Organisation (UNESCO), a worldwide organisation which works to create effective dialogue between its member states, not only recognises the concept of cultural competence but endorses it as an important component in its mission to build competencies in education, science and culture. It described cultural competence as a programme’s ability to honour and respect beliefs, interpersonal styles, attitudes and behaviours of families, clients and the multicultural staff who are

providing services. In its 1998 World Conference on Higher Education, UNESCO identified that higher education institutions must provide sound initial education but also establish themselves as places where individuals return to renew their professional and cultural competence (UNESCO, 1998). Cultural competence is an on-going theme within the organisation and in 2010, International Year of Rapprochement of Cultures, one of the main aims was to raise awareness and promote cultural diversity (UNESCO, 2010). The definition and interpretation of cultural competence adopted by UNESCO is similar to many others but the emphasis appears to be on people rather than systems.

Since the current study began the vast movement of people and changes in national boundaries across Europe has intensified developments to demonstrate culturally competent practices, not only in health care but across many sectors in the evolving communities. Stories continue to unfold regarding underlying themes of marginalisation, miscommunication and exclusion which affect disenfranchised communities with a call for practitioners to develop knowledge of culture and health care systems anchored in research (Papadopoulos et al, 2004). The adoption of cultural competence within its policy documents across member states of the European Union is not obvious. Writing on cultural competency in Germany, Schultz (2004) remarks that the concept is much theorised but unfortunately its practical application has only been seen sporadically in individual institutions, individual psychologists and psychiatrists without any institutional or state planning being apparent. He concludes from the study which compared clinical experiences

in the United States (US) and Germany, that cultural competence is necessary and is a practice in which everyone involved benefitted.

The UK is probably one of the few member states which have implemented data collection, albeit limited, on ethnicity and this data is being used to address inequality although it would seem to be extremely variable. As far back as 2004, the NHS identified that training in cultural competence should be developed and rolled out for all sectors of the health care workforce and that in all clinical areas measures and definitions for organisational cultural competence should be developed and incorporated into the standard quality assurance procedures of the NHS (DH, 2004). Developers of undergraduate programmes are required to demonstrate that quality assurance strategies are in place for the programmes they deliver. The achievement of learning outcomes is an integral part of this process and undergraduate courses are required to publicise them (Quality Assurance Agency, 2008). However, cloudiness of cultural competence in how it is measured and used across governmental agencies, HE, stakeholders and the public has implications for the construction and consequent learning outcomes for health care undergraduates (Gozu et al, 2007).

Defining cultural competence

It is not immediately obvious from the literature, or from current usage what is meant by the term (Kumas-Tan et al, 2007). Independent definitions of the two words from which the term has been derived ‘culture’ and ‘competence’, have themselves provoked lengthy analyses by social scientists, educators and

professionals without an agreed consensus on either term. It appears that the definition of cultural competence has remained locked in to individual perceptions and contexts. There is also little indication that its conceptual meaning has been investigated in a comprehensive manner in existing programmes of health care. Indeed, the majority of current evidence points towards a lack of research in dealing with the conceptual nature of the topic (Lo and Stacey, 2008). Below is an investigation of the two terms 'culture' and 'competence' and an attempt to identify how their combined meanings have contributed to current debates and models of the concepts we now have in place.

Culture

Definitions of culture are said to denote a way of life, and to be people's shared experiences and the schema they acquire based of those experiences (Strauss and Corbin, 1990); Fernando (1989) assumes that it is characterised by attitudes and behaviour, determined by upbringing and choice, and is changeable. Hall (1984) proposes three levels of culture: the explicit manifest culture ('tertiary level culture'), which is visible to the outsider and known to the members of the cultural group themselves such as cuisine, festivals and dress. A second level, – the public facade presented to the world at large e.g. beliefs, rules. The third and deepest level he describes as 'secondary level culture' where rules and assumptions are implicit to the group but are rarely shared with outsiders. 'Habitus' – functioning below consciousness is the phrase coined by Lo and Stacey (2008) which attempts to explain this deep level. This deep level is identified as the most resistant to change and the least open to manipulation. However, one should

guard against the inclination to make generalisations based on categorisations since differences between individuals may be just as marked as the differences between cultural groups. Within cultures, there are likely to be further categorisations based on socioeconomic factors, age, colour, sexual orientation, mental and physical ability and other variants. Interpretations and categories of culture are often fluid, complex and transnational; therefore, it is important that the context of culture is interpreted and conveyed accurately for effective communication. Additionally, further superimposed subcultures may exist, for example status and hierarchical levels within professions such as physiotherapy, nursing and medicine. Here, the novice gradually adopts the behaviours of qualified practitioners and upon qualification assumes a new status. As a consequence, an additional interpretation of culture is that it could be viewed as an identity.

Within social science, culture has been studied from a number of perspectives including behaviourism, culture, psycho-socialism, neo-materialism, structural determinism, multiculturalism, antiracism and social realism, but few researches have investigated its conceptual underpinnings within the notion of cultural competence. There is support for positioning the concepts of culture and cultural competence within the social sciences from Bourdieu (1990) who describes culture relating to patients as lying in the realms of ‘social practices’ and ‘habitus’. He relates social practices with different groups of patients and uses the term ‘habitus’ to describe internalised mental structures below consciousness embodied in individuals which are situational, improvisatory, patterned and with contextual

differences. Lo and Stacey (2008) suggest that the use of ‘habitus’ offers a conceptual language for a cultural mechanism such as culture which hitherto has lacked clarity. In their suggestion, they have veered away from the term cultural competence preferring to use the term ‘cultures’. This theoretical reformulation by Lo and Stacey (2008) of the role of culture applied to clinical settings in the form of a ‘hybrid habitus’ is based not only on the work of Bourdieu (1990) but also that of Sewell (1999). Their proffered notion is said to broaden the understanding of culture, conceptualise culture both systematically and flexibly, and recognise how the enactment of cultural schemas is contingent and contextual-bound. However, this position leaves the question of ‘competence’ open to debate. The argument forwarded by Lo and Stacey (2008) is that while medical practice has been standardised at the expense of cultural considerations, the reduction of culture to a formula in the form of standardisations which may be assumed to be part of competencies and algorithms do not provide an answer to the problem. Their call is for more systematic documentation and analyses of case studies for cultural competency courses to inform practice.

Sewell (1999) does not speak directly of health or cultural competence but within the realm of social science offers a view of the variations amongst individuals with similar ‘structural’ locations. He suggests that these are likely to be the result of different configurations of structural intersections and this allows us to think about the variability and idiosyncratic nature of individuals within a cultural context and that differences and variations may be patterned. However, this view appears to be unrelated to competence.

In informing the development of policies and interventions to address inequalities in health, Mansyur et al (2009) attempt to formulate a theoretical framework that combines constructs from sociological theory including Bourdieu's cultural structuralism and cross-cultural psychology. They describe how the socio-cultural context may influence health across three levels: the macro level where structural, political, environmental, cultural and historical contexts are considered, the meso level where cultural norms, social institutions and social groups exist, while at a micro level genetic factors as well as identity, personality, behaviour, psychological, demographic and interpersonal processes are described. They conclude that only when all levels are taken into consideration is it possible to put in place the right policies and interventions.

Competence

As in attempts to define culture, definitions of competence are context bound. A more useful definition may be gained if the term 'competence in…' is defined instead of mere competence. Many writers have attempted to clarify the meaning of competence in higher education with varying degrees of success. Stengelhofen (1993) describes a model of professional competence that encompasses knowledge, skills and attitudes at different levels. In the lowest tier of the hierarchy are observable activities and professional relationships, a second level involves reflection on knowledge which becomes more systematic until finally the individual reaches the more elusive attributes which encompasses values and attitudes which are more difficult to measure. One picture of cultural competence depicts a

move from its previously itemised constituents – a reductionist and mainly behaviourist approach – to an account that incorporates not only performance and practice requirements but also intellectual and professional dimensions (Edwards and Knight, 1995). If we assume that competence can be assessed, the overall belief appears to be that, by whatever means it is assessed, it is an *outward* and *visible* interpretation of the activity or activities displayed in a particular context.

Models of competence have garnered ethical, epistemological and political criticisms. Tarrant (2000) argues that from an epistemological perspective, it is difficult to separate performance from the underpinning knowledge. From an ethical point of view, competence embodies morality in attitudes inherent in courses alongside knowledge and behaviours and social considerations. In this vein, Lum (1999) dismisses competence-based education on its 'artlessness', naïve assumptions about language and its disregard for the complexity of human action.

Commonly, the two dimensions often associated with competence, especially in relation to professional competence, are scope (roles and tasks) and quality (level of expertise) as identified by Roach (1992):

> The state of having the knowledge, judgment, skills, energy, experience and motivation required to respond adequately to the demands of one's professional responsibilities (p. 61).

Criticisms surrounding the notion of competence which breaks down complex behaviours into simple sub skills as tasks, stifling creative learning and pre-specified learning objectives are also pervasive from authors such as Barnett

(1994) and Bates (1995). These were thought to be to the detriment of assessment of higher intellectual processes and considerations surrounding a more reflective practitioner model became increasingly evident in the literature based on the writings of individuals such as Schon (1996). The model argues that the greater influences on learners in a particular context are not competence and behaviour training but rather prior beliefs and personal theories. This approach is not far removed from the idea of the elusive and hard to measure attributes highlighted by Stengelhofen (1993).

However, it would seem that competency frameworks are receiving a resurgence. Suggestions as to why this may be the case include the need to plug gaps in skills and to respond to changing skills profiles required in the workforce. It is thought that a competency framework might also help to identify and validate certain tacit competencies. Sultana (2009) suggests that concerns about quality assurance and greater accountability may mean that identifiable competences can in principle be measured and tested. A recent re-launch of the government website 'Skills for Health' confirms that the achievement of competence as a concept in health care within the UK has been firmly embedded in the approaches to be adopted in managing the heath care of the nation.

Within physiotherapy, a distinction has been drawn between competence and continuing professional development. Gosling (1999) suggests that in considering competence, the focus may be more on the maintenance of safety through tasks which are reductionist and is often driven by the needs of organisations. However,

she acknowledges that characteristics of competence can be multifaceted and multileveled, fulfilling individual professional responsibility, and that it could encompass recognition of the individual's scope of practice whilst at the same time fulfilling the needs of organisations. Thus, a view exists that it could be broadened to include ethical and emotional dimensions and to be more encompassing. A requirement in physiotherapy education is to ensure a minimum standard, recognise the ability of the individual, address poor/under-performance, and deal with unsafe practice. This identifies that a certain minimum level of competence is expected as well as continuing professional development as regulated by the HPC.

The more traditional view of competence is one which incorporates knowledge, skills and attitude (McGaghie, 1991) but more recently, a broader framework that incorporates professional ethics and dimensions of client and patient measures such as trust have also been considered (Cant, 2009). It appears that as a concept in physiotherapy education, the notion of competence is becoming increasingly founded on a more integrated view which considers these factors (Sultana, 2009). Attempts to encompass a behaviouristic tradition – associated with developments on the topic in the US; a functionalist approach – pervasive in occupational standards in the UK; and a greater holistic dimension that stems from other parts of Europe may be emerging. Approaches in physiotherapy education such as reflective practice, independent learning, problem-based learning, blended learning, team learning and project-based assessments utilise integrated models of learning and teaching which attempt to show differing and complex aspects of

competence. Deciphering competence and thereby implications for learning and teaching, in order to arrive at standardised frameworks which offer service users and practitioners practical approaches to explore, develop, understand and assess continues to be a challenging exercise.

Cultural competence

In seeking to define cultural competence, the individual definitions of the two terms of culture and competence, bring their own complexities where examination of values, attitudes, ethics and emotion are important dimensions which do not lend themselves easily to measurement. In addition, interaction between two of its common components i.e. the individual and the context, are dynamic, interdependent and not always predictable.

The US has been a world leader in the dissemination of information on the topic of cultural competence and in 2001, the USHHSOMH published National Standards for Cultural and Linguistically Appropriate Services (CLAS) Cultural competence is defined as a:

> …set of congruent behaviours, attitudes and policies that come together in a system agency or among professionals that enables effective work in cross-cultural situations (USHHSOMH, 2012 adapted from Cross et al, 1989 p.28).

A culturally competent programme is referred to as one which demonstrates sensitivity and understanding of cultural differences, not only in programme design, but across additional dimensions in the way it is implemented and evaluated (USHHSOMH, 2012).

Various terms have been used individually and in combination with others to describe cultural competence. There is a danger that concepts might not have been examined carefully, and this could have implications for its incorporation in undergraduate education. Although increasing numbers of writers have suggested ways of promoting, understanding and developing practices in this area for qualified practitioners, it has been rare to find its component parts and relevance explicitly addressed within undergraduate health care programmes including physiotherapy. However, a number of models have been forwarded which might assist in addressing this deficit.

Models of cultural competence

Existing models of cultural competence hold relevance for understanding how cultural competence might be explored within physiotherapy. Medical anthropology and medical sociology have been strongly influential in the development of the concept. Given that these areas of study consider the relationships between social, environmental and cultural aspects of treating disease, it may not be altogether surprising that cultural competence has provided a useful bridge in spanning them in discussions surrounding the management of health. In contemplating this bridge in nursing, Dr Madeline Leininger (1985, 1976) established a foundation of transcultural care which has influenced developments in other professions. Her work, including Theory of Culture Care Diversity and Universality, has been pivotal in informing nursing practice in recognising and

addressing ways in which belief systems, values and behaviours affect one culture upon another.

The concept of culturally congruent care takes account of individuals, families, groups and institutions in the care encounter. It is one of the most commonly quoted models and is often referred to as the Sunrise Model. Cultural care from an anthropological perspective is examined through seven cultural and social structure dimensions. These dimensions are said to be cultural values and life ways (1), religious, philosophical and spiritual beliefs (2), economic factors (3), educational factors (4), technological factors (5), kinship and social ties (6) and political and legal factors (7). It is suggested that information gathered on these aspects offers guidance on transcultural care decisions and actions applied through cultural care preservation/maintenance, cultural care accommodation/negotiation and cultural care repatterning/restructuring and vice versa. Although this model is centred on care within a nursing context it is pertinent to physiotherapy if it is recognised that physiotherapy students may be akin to nursing students as ‘enthusiastic users of theory’ and that they too realise the challenges that working across cultures might bring.

In further critique, she refers to an informant’s ‘emic care constructs’ as being invaluable in explaining, developing and guiding nurse’s actions as they give clues as to how individuals expect to receive culturally congruent care. She also recognised the illusiveness of eliciting cultural care constructs partly because of the manner in which they are embedded in cultural values, kinship, religious

systems and environmental contexts. This view was one of the prompts for contemplating use of the repertory grid (RG) technique in this study. It offered opportunity to tease out constructs of students' perception of cultural competence and to analyse their understanding of it in delivering culturally congruent physiotherapy and identifying challenges which it might present. Leininger recognised the possibility of developing hypotheses and conducting quantitative research studies from qualitative findings in offering different perspectives in care. Repertory grids are understood to hold the potential to analyse both qualitative and quantitative data. Additionally, her Sunrise Model formulated within a context of language and environment and from a number of dimensions is said to offer a choice of focus linked to individual interest (Leininger and McFarland, 2002) and for me, the focus was cultural competence as perceived by student physiotherapists.

Early in the examination of cultural competence, Cross et al (1989) introduced a model of cultural competence showing behaviours which ranged from cultural destructiveness to cultural proficiency. It starts from a position where destructive attitudes, policies and practices, stereotyping, biased organisations and ethnocentricism might prevail and moves to one of respect and acceptance for difference. It is said to offer opportunity to become proactive in developing cultural proficiency. The model also takes account of self-awareness, cultural knowledge and skills to promote effective socio-cultural interactions which are also now reflected in many other models. The point at which students in the current

investigation presented on this continuum of cultural competence was surmised, and therefore it was considered worthy of further investigation.

Whereas Madeleine Leininger's work is commonly associated with the notion of transcultural care, the writings of Josepha Campinha-Bacote are much quoted in studies investigating cultural competence. 'The Process of Cultural Competence in the Delivery of Health Care – The Journey Continues' is stated as a practice model in health care. She defines cultural competence as

> the on-going process in which the healthcare professional continuously strives to achieve the ability and availability to work effectively within the cultural context of the patient (individual, family and community) (2007, p.15).

In her initial model, cultural competence was depicted as encompassing cultural awareness, cultural knowledge, cultural skill and cultural encounter. This model was later depicted as a process incorporating cultural desire, a theme developed pictorially and symbolically as an erupting volcano (Campinha-Bacote, 2007). Eruption of cultural desire is portrayed as the basis for the fulfilment of the original four areas of cultural competence. In becoming culturally aware, individuals are said to become more sensitive to their own values, biases and those of others and to diversity in attitudes and beliefs of different communities, whilst attainment of cultural knowledge assumes that the individual will be cognisant of world views, socioeconomic epidemiological and demographic influences. In developing cultural skill, individuals are able to incorporate culturally appropriate assessments and to interpret findings in order to achieve appropriate interventions. This skill takes into account respect, trust, reflective practice and use of tools used in encounters

which lead from reflection and learning into culturally appropriate care. The students' journey in their understanding of cultural competence, including their desire to make that journey through portrayal of the perceptions they shared in the investigations, had the potential to offer new insights and implications on how the topic might be learnt and taught in undergraduate physiotherapy.

Borkan and Neher's Development Model of Ethnosensitivity (1991) explore health professionals' ability to move from a position of ethnocentrism centred on cultural blindness and denial to ethnorelativity where there is acceptance and empathy. Further stages within this model of negative stereotyping and minimisation have to be overcome before the latter stages may be reached. Although this model begins with a similar lack of awareness or ethnocentrism seen in other models, it would seem that arrival at the entities of acceptance and empathy are limited in identifying how the professional continues to be proactive in this regard in their professional lives. However, aligning student perceptions of cultural competence with this model had the potential to confirm commonalities seen in other models.

Bennett (1993) shows six stages in developing cultural competence – denial/avoidance, defense/protection, minimisation, acceptance, adaptation and integration. The starting point, a lack of awareness, is similar to other models but the introduction of self defense mechanisms such as belief in one's superiority and denigration of other cultures as negative aspects of this continuum receives greater emphasis. Like Borkan and Neher (1991) minimisation is also a feature but as well as trivialisation of differences, similarities in cultures are emphasised.

Stages of acceptance, adaptation and integration are said to signal a lead into the cultural proficiency similar to that described by Cross et al (1989). Within this model, efforts are made by the professional to evaluate different behaviours and values from different cultures and to integrate them into clinical practice. It was not known the extent to which students might engage with this approach.

Cultural competence as viewed by Giger and Davidhizar (2002) in the Transcultural Assessment Model identifies six cultural phenomena of communication, space, social organisation, time, environmental control and biological variation. These are said to be embedded in cultural heritage, attitudes and behaviours and provide individuals, systems and agencies with a means through which to explore cultural competence which is said to be fluid, dynamic and continuous. Space, time and biological variation are two phenomena which appear to have a greater focus in this model, more so than in others. The phenomena of space explore personal boundaries while time explores the past, present and future. Within biological variation, as with other models, diseases specific to cultural groups and nutritional preferences are considered, and physical attributes are considered to a greater extent. Whether students would encapsulate these dimensions through their communications was unknown.

The Purnell and Paulanka Model for Cultural Competence (2008) attempts to explore cultural values, beliefs behaviours and health care practices and like Doorenbos et al (2005) includes all individuals across the episodes of care. Individuals are purported to move from unconsciously incompetent, consciously

incompetent, consciously competent to unconsciously competent, analogous with learning a new skill. Initially, the individual is unaware of the level and nature of their incompetence but then comes to acknowledge levels of incompetence and seeks to address it, eventually assuming a degree of expertise where they become unconsciously competent. The extent of student's unconscious incompetence and competence was to be explored through the adoption of different lines of investigation. The model is often presented as concentric circles with the outer circle being representative of global society while the successive inner circles are representative of community, family and person, consecutively. The penultimate inner circle is divided into twelve equal inner segments demarcated as spirituality, death rituals, pregnancy, nutrition, high risk behaviours, biocultural ecology (skin colour, genetics etc.), workforce issues, family roles and organisation, communication, overview/heritage, health care practitioners and health care practices. The innermost and smallest circle remains unidentified. Whilst these areas are spelt out in detail, areas cited as worthy of further consideration in other models, for example the influence of technology, receive scant recognition which is now an area of rapid development. The model offers in-depth detail on a number of parameters on which students perceptions could be evaluated.

The Papadopoulos, Tilki and Taylor model for developing cultural competence was first published in 1998 and has undergone further refinement more recently (Papadopoulos, 2006). The underpinning values are professed to be based on human rights, socio-political systems, intercultural relations, human ethics and

human caring. More specifically these are identified through the individual, culture, structures within society, institutions and families, health and illness, caring, nursing and cultural competence. Four stages are offered as a continuum: cultural awareness, cultural knowledge, cultural sensitivity and cultural competence. Achievement of the final stage is said to require synthesis and application of awareness, knowledge and sensitivity gained in the previous three areas. It offers a further focus on assessment of need, clinical diagnosis and other caring skills. Ability to recognise and challenge racism and discrimination in other forms and oppressive practice are stated as additional abilities required in the process. However, in arriving at this fourth stage further questions arise regarding the significance of the timing of where and at what stage discriminatory practices might be addressed, especially in the process of developing clinical competence in undergraduate learning and teaching. The timing and relation of this topic to professionalism and continuing professional development was considered worthy of further attention in these investigations. Papadopoulos (2006) make a differentiation between the development of culture-generic competencies before the development of culture-specific competencies and in so doing identify specific areas from the works of Campinha-Bacote (2003) and The Sunrise Model in guiding nurses towards culturally competent assessments. The extent to which undergraduate physiotherapists were able to display practices at any of these levels was unknown.

Other researchers have also developed other useful guides to practice and adjuncts to these models. Doorenbos et al (2005) present a puzzle metaphor for

care which demarcates cultural diversity (a fact of life), cultural awareness (cognitive construct), cultural sensitivity (affective or attitudinal construct) and cultural competence (behavioural construct) as themes to be explored. These are viewed as non-linear and interconnected. However, unlike a number of the other models, within this model, one of the main areas of focus is recognition of the client, families and communities as being of equal importance as the professional. The model is said to be still evolving (Leavitt, 2010). The extent to which undergraduate physiotherapy students portray the balance of these relationships and their interconnectedness within the context of cultural competence has also been unexplored.

A number of other models now exist which have at their heart awareness, attitudes and skill, and include CLAS – the standards for Culturally Competent and Linguistically Appropriate Service which provides a blueprint for health professionals to develop services for their clientele. Analysis of this alongside other models outlined above, offered a focus for analysing student perception of cultural competence within their undergraduate programme and to explore associated learning and teaching needs.

2.2 Cultural competence in learning and teaching and undergraduate health care

To date, no studies have been identified that measure the cultural competence of undergraduate physiotherapists within the UK. Therefore, exploration of the literature takes into account studies which may be seen to have significant

implications for developments in this area. Investigations in health care education, especially within the US, have studied the development of cultural competence in physical therapists, nursing and across a number of professions, but a number of these published studies were conducted using qualified staff as opposed to undergraduates.

The few studies which have investigated the perception of cultural competence within undergraduate programmes have adopted a mainly qualitative approach. The topic does not lend itself easily to the use of randomised controlled trials or experiments, and as Lo and Stacey (2008) suggest much research lies in gathering in-depth data of cases. It has also been suggested that developing expertise in how data may be best used in studying individual experiences, observations of human behaviour and 'trial and error' may serve as a guide to developing further knowledge and understanding of the topic (RNAO, 2007). Historical developments and the way in which the term has evolved have meant that most of the studies have been done relatively recently, and in general they have resorted to use of questionnaire survey.

Brennan and Cotter (2008) used the 31-item Blueprint for Integration of Cultural Competence in the Curriculum (BICCC) to survey student nurses' perception of the inclusion of specific items relating to cultural competence in undergraduate and graduate courses. The survey was conducted within the context of the US, and specific items were supplied to the students to see whether cultural competence was integrated into their programmes of study i.e. the study did not

appear to set out to capture perceptions of the students' cultural competence per se. The BICCC was developed from a previous 67-item tool used in Assessing Cultural Competency Training in the clinical encounter for medical students. The study was purported to assist the researchers in building a framework which conceptualised dimensions of cultural competence as well as addressing students' perception of their educational experience. The tool was used primarily to identify omissions and deficiencies in the cultural competence education of the students. Students in successive years up to master's level were surveyed and they expressed health disparities in research and theoretical formulation of culture, health and nursing as remaining challenges. It is assumed that unlike the current study, established programmes on the topic of cultural competence had been in existence for some time across the faculty. It is not known whether these programmes could be established in a similar way within the UK and further enquiry into the approaches adopted might be useful in establishing the extent to which this might be possible.

A further study investigating students' perceived cultural competence was conducted by Caffrey et al (2005). However, this was conducted with undergraduate nurses where a group of seven students were exposed to international nursing in a five-week clinical setting Integrated Cultural Content Plus (ICC Plus) programme while 25 of their counterparts followed the Integrated Cultural content (ICC) programme only to see whether an additional placement had any effect on their perceived cultural competence. The Plus was the additional international experience offered to the identified group. The measurement tool was

a 28-item scale, the Caffrey Cultural Competence in Health Care Scale (CCCHS) which required the 32 students to rate themselves on perceived knowledge, self-awareness and comfort with skills. A pre-test was conducted on admission to the programme and a post-test just prior to graduation. The impact of other possible variables in the intervening period which could have influenced the reported outcomes were analysed but the international experience was said to have played a critical role in students developing confidence in nursing skills. This cultural immersion was considered to be more than the awareness students developed in reacting with culturally diverse groups in practice settings because of the daily reality experienced in the international setting. Caffrey et al (2005) suggest that for those students who are unable to have 'the immersion experience' that perhaps a cognitive level of cultural competence is all that can be expected. The current study did not envisage that all health care students would have an international placement during their undergraduate programmes but consideration about the inclusion of experiencing 'daily realities' of a variety of cultures in order to increase engagement with diverse cultures was considered. Using an international experience to develop cultural competence may be worthy but the practicalities and financial constraints for some students could have been a limiting factor.

Davis (2007) used concept mapping to generate maps reflecting indicators of cultural competence as perceived by family and professionals in four children's mental health care community settings. This may be one of the few studies which attempts to delineate important aspects of cultural competence across specific communities for professionals and their clients. Concept mapping was used in a

mixed method approach in a qualitative research design and combined elements of quantitative analysis. Brainstorming was adopted to gather words and concepts from participants and multivariate analysis to provide a structure from which further analysis was conducted. Different priorities and needs were found across the four systems of care and the findings were said to illustrate the need to assess provider and user perspectives. Untangling individualised care from culturally competent practices was cited as one of the main outcomes from the study. It was argued by the researcher that if standardised measures of cultural competence were to be adopted, then there is a risk that the tool may not capture essential aspects relevant to specific communities and that other approaches may be needed to understand differences and similarities in specific communities. Concept mapping was said to offer potential to address these differences. The use of repertory grids instead of concept mapping was contemplated in this study as an alternative and established approach for capturing constructs, as it had been found to be useful in practice elsewhere and within the literature.

Rather than investigating undergraduate students and cultural competence, Bogg et al (2007) investigated physiotherapists' perception of equality and diversity in the NHS and the profession. While this study does not investigate cultural competence, it offers some insight into how issues of inequality are viewed by physiotherapists. Of the 420 respondents, 88% were of a white ethnic background, 12% non-white. Evaluation of the responses concluded that nine percent (n=33) of white ethnic physiotherapists reported being treated differently by patients or relatives compared to 33 percent (n=20) from a non-white ethnic background.

Bogg et al (2007) identify that it is apparent that physiotherapists working within the NHS still perceive that problems exist in equality, diversity and career progression and that it is imperative to address these workforce perceptions. Although perceptions are an individual's view of reality, they suggest that if a significant portion of the workforce share and describe a common reality which is vastly different to the workplace reality and or objectives, then there may be a cause for concern. In exploring the perception of the undergraduate students, the workplace reality for them in the area of cultural competence was unknown. In conducting this study, the hope was that commonly held views might become more apparent and that these might inform learning and teaching and further enquiry.

In researching the topic with other AHPs, Murden et al (2008) identify that cultural competence is now an essential component in the educational objectives in occupational therapy frameworks. The study set out to evaluate US graduate students' perceptions of cultural awareness and to examine their self-rated level of cultural competence at four stages of education i.e. at entry through to one year following graduation. Although this study examined 72 graduates and the subjects were occupational therapists, the approach of using self-rated assessment of cultural competence is similar to the approach of using self-assessment adopted in the present study. The study adopted a Cultural Awareness and Sensitivity Questionnaire (CASQ) which was said to have been used in a survey of British and Australian occupational therapists. The subjects identified the need for increased exposure to a wider range of cultures and teachings in cultural

differences, and culturally sensitive care was said to be limited. Students who were one year post graduation felt that on entering fieldwork their course had offered them limited appreciation of the impact of culture and that this could potentially lead to errors in planning programmes of care. They confirmed a lack of awareness, limitations in the curriculum and decreased levels of confidence in students which were purported to affect their ability to be or to become culturally responsive therapists. Murden et al (2008) support the use of case vignettes as suggested by Munoz (2007) which take in the complexities of the individual differences and environmental factors when teaching the subject. The suggestion is that future studies should attempt to monitor actual culture – related exposures during university-based studies so that they become part of life-long learning. The study highlighted the need to find ways and means of immersing cultural competence into the undergraduate curricula of health care students and offered support for developing the present study.

Kraemer (2001) investigated the perceptions and experiences of master's degree physical therapists regarding the provision of culturally congruent cross-cultural care in the clinical setting. In contemplating this study, not only was it specific to the US but it was drawn from a clinical setting which makes direct comparison to the current investigation difficult since data in the current study was drawn from both clinical and academic settings. The present study also identified the perception of students as the main focus while there was some lack of clarity regarding this in the study by Kraemer (2001). Nonetheless, the findings offer useful insight. Using a sample of 12 second year master's degree students,

Kraemer (2001) found that students reported a lack of clinical preparation, a lack of awareness of barriers, clinical culture clashes and a lack of available resources. The intention of this study was also to investigate where there might be possible barriers but within a cohort of undergraduate physiotherapists.

Confirmation of the need for the development of cultural competence in physiotherapy and occupational therapy undergraduates was also apparent in an investigation of cultural awareness carried out by Kale and Hong (2007). It is worth noting that in the studies by Kale and Hong (2007) and Murden et al (2008), the phrase ‘awareness of culture’ was often used interchangeably with the term ‘perception’ and omission in the researches in defining these two terms has made direct comparison of the researches difficult.

It is becoming increasingly clear that investigations of cultural competence continue to be dominated by literature from the US, but recently a systematic review entitled ‘Systematic Review on Embracing Cultural Diversity for Developing and Sustaining a Health Work Environment in Healthcare’ was published by Pearson et al (2007) which is a coalition between Canada and Australia. Although the title does not suggest that the study was conducted to investigate cultural competence, further scrutiny of the report identified that the main objective was to evaluate evidence on structures and processes that support development of effective cultural competent practices and a healthy work environment. The view taken by the authors was that cultural competence was a measure of the extent to which systems were able to provide care to patients from diverse backgrounds,

including how they might be tailored to individual social, cultural and linguistic needs. Emphasis in the review was placed on the identification and inclusion of other systematic reviews, randomised controlled trials, quantitative evidence from other controlled descriptive designs and qualitative studies incorporating different designs. The review identified 659 papers but only 19 met the inclusion criteria at a level considered worthy of follow up by the authors. The study confirmed variations and confusion in terminology and frameworks for examining the concept of cultural competence and a degree of interchangeability between the terms used in defining it.

It was reported that in education and training, there was evidence of various training content and delivery options and the use multifaceted interventions and provider interventions. This picture accords with the current position of the learning and teaching of cultural competence in physiotherapy education where there are different approaches to dealing with the topic within curricula and challenges in measuring its outcomes in student learning. There was evidence to suggest that cultural competence training could improve the attitudes and skills of healthcare providers and favourably affect patient satisfaction. Its findings were consistent with the view of the London Deanery: to recognise cultural competence as part of practitioner development and that training could make a difference in positive outcome measures for patients. Organisational commitment was cited as an important requirement in providing culturally competent care. The review concluded by identifying a real need to ensure that organisations are able to support and produce culturally competent practitioners. Although this investigation

was centred on qualified staff, there is a strong body of evidence that supports the view that in general, undergraduate training is needed to tackle the early professional development and competence of an effective workforce (Garcia, 2006; Cuellar et al, 2008).

In attempting to gain an overview of undergraduate physiotherapists' perspective on cultural competence, the picture is made more complex by the great variation in how tools have been employed in defining, measuring and exploring it. Their development have often been inevitably context bound and the different ways in which they have been developed in different countries and situations could limit the extent to which they can be adapted to other contexts. Additionally, it is expected that members of an institution are guided by its policies and strategies and that they may use these in the achievement of identifiable outcomes relevant to their own setting. Therefore, although models, guides and curricula are extremely useful in developing approaches to care and related health care practices, different settings may require further in-depth consideration of the interrelationship of these additional factors and how best to operationalise them within specific contexts .

Learning and teaching cultural competence in undergraduate health care education and physiotherapy

While the professional bodies continue to wade their way through terms and interpretations on how to deliver 'equality', evidence for the effective learning and teaching of cultural competence and equality and diversity in undergraduate

curricula continues to be sparse, there is little consensus on approaches to learning. London Deanery (2012), Stewart (2002) and O'Shaughnessy and Tilki (2007) have identified this continuing lack of curriculum guidance and have made the call for appropriate investigations at undergraduate and postgraduate levels. In a similar context, Hunt (2007) has also remarked that physiotherapists need to develop greater insight into understanding their patients' experience of disability and illness from different perspectives. Rectifying omissions in guidance in these areas for developers of physiotherapy curricula needs to be addressed. There is strong motivation to establish 'cultural diversity training' (Bentley et al, 2008), diversity education (Dogra, 2005), culturally competent research and scholarship (Saltus, 2006) and to develop measures that truly evaluate it (Kumas-Tan et al, 2007).

Hunter et al (2008) used standard university evaluations of course and instructor methods to investigate cultural competence. They developed a course based on four of Campinha-Bacote's (2003) five constructs of cultural competence – cultural awareness, knowledge, skills and encounters for a group of graduate students using both online and classroom teaching methods and materials. The study adopted a constructivist learning theory approach as its philosophical basis as this was viewed as a method which would support students from vastly different backgrounds, promoting respect for varied life experiences and building on existing knowledge, perceptions and values. A constructivist approach which uses enquiry to assess developmental needs, interests and backgrounds of learners was found to be successful in eliciting insight and growth in students in different

stages of cultural development, and to some extent supports the approach adopted in the present investigation. Hunter et al (2008) also concluded that well designed and supported online learning to promote discourse may be a way forward but a facility to do this was not available at the time of the present study.

Engaging students in the learning and teaching of cultural competence can be challenging and Chun (2010) and others have identified that there are many influences on students' openness to diversity. Poirier et al (2009) assessed the development of cultural competency in a course on health promotion and literacy designed for pharmacy students. They cited an initial disinterest or ambivalence in some students and apprehension at being outside of their comfort zone. Challenges in developing appropriate class activities in engaging students in a non-scientific topic were overcome when students became more aware of their personal biases and the impact of health belief models on patient care. Methods of accurately assessing appropriate levels of engagement alongside consequent individual, institutional and patient benefits are limited within the literature. However, in a mailed survey to 170 baccalaureate nurses, Kardong-Edgren (2007) assessed factors which were helpful in increasing comfort levels as well their levels of cultural competence. It was identified that there was increasing inclusion of 'cultural content' in nursing programmes and the students were within the culturally competent range of the IAPCC-R (Kardong-Edgren, 2007). The findings in this study are inconsistent with those of previous studies such as DeSantis (1990) and Kulwicke and Boloink, (1996) which identified a lack of cultural competence in nurse students. However Kardong-Edgren (2007) recognised that a

lack of standardisation in the tools of measurements adopted may have been a confounding variable. This study also revealed that students' immersion, working and mixing with other cultures were important factors in increasing their level of comfort when taking care of people from other cultures.

Methods suggested for incorporating cultural competence in undergraduate curricula by professional bodies and institutions in HE vary from mere ideological explanations to suggestions for full immersion of students into 'new' cultures (Wood and Atkins, 2006; Hughes and Hood, 2007). Despite this variation, the growing importance of the topic remains undiminished. In 2004, the Liaison Committee on Medical Education added cultural competence as a standard for accrediting medical schools while in 2008, the American Physical Therapy Association (APTA) published its blueprint for teaching cultural competence in undergraduate physical therapy.

One of the models adopted by the APTA is the 'Explanatory Model' by Kleinman et al (1978) where questions are used to explore differences in individual's perspective of illness and disease. Diversity dimensions that have traditionally resulted in discrimination in the US and specific health disparities relating to each dimension are considered alongside incorporation of the LEARN Model for developing culturally effective communication. The acronym LEARN is derived from the activities of listening, eliciting, assessing, recommending and negotiating as identified by Berlin and Fowkes (1983). Common strands of the client-centredness of this approach, and many of the overarching goals, knowledge,

skills and attitudes identified, offer scope for developing cross-cultural translation of a common knowledge base for the topic (APTA, 2008) but currently these have remained untested within the UK. Thus, the US would seem to be some way ahead in the implementation of cultural competence within the physical therapy curriculum nationally but its direct translation into the UK might not be desirable, appropriate or practically possible because of contextual differences. Similarly, material written in English from further afield from Australia, New Zealand and Europe may pose their own limitations on the extent to which interpretations can be introduced into curricula and health care systems within the UK.

The government's Knowledge and Skills Framework – a UK wide framework which is said to apply to everyone who works in the health sector to 'focus on what the person needs to be able to do, as well as what they must know and understand to work effectively' – appears set to direct the 'competencies' physiotherapists might be required to demonstrate (SfH, 2008). Skills for Health (SfH) does not adopt the term 'cultural competence' but the competency requirements in this area are set out under the banner of Equality and Diversity. In fulfilment of competencies in equality and diversity, it is expected that a physiotherapist at level five (graduate) is able to ensure that their actions support the equality, diversity, rights and responsibilities of individuals. Although these expectations and requirements are stated, there is little guidance on how they might be developed and achieved. Again, the omissions here leave educationalists at liberty to make their own interpretations, and possibly to continue to fuel the lack of coherence in the learning and teaching of the topic. In order to guide practitioners, the CSP offers

guidance on how to meet the requirements of this core KSF – Dimension Core 6, Equality and Diversity – but confusingly terminology is at variance to the documentation because it adopts the term cultural competence (CSP, 2007).

Historical development of associated terms within the literature

Historically the term cultural competence has been interchanged with other terms and its origin is difficult to extricate from the numerous descriptors that have been used over time to identify practices which relate to equity. The term surfaced and became increasingly evident in the psychological, education and nursing literature in the 70s, 80s and early 90s. However, the first person who may have introduced the term in 1927 was Dr Carter G Woodson, an historian and Harvard graduate born to enslaved parents, who thought that much of the divisiveness in society which was based on racial and cultural misunderstandings and lack of knowledge could be addressed by increasing the knowledge base of its peoples (Hanley, 1999). Another early writer on the topic was Prichman (1965) who wrote in respect of American international business management. Others included Driver (1977, 1980), Tomine (1980), DeSantis (1990) and Hek (1991). However, the seminal works of Madeleine Leininger including her publication of 'Culture Care, Diversity and Universality Theory' have been pivotal in addressing the topic of transcultural care within the profession of nursing and beyond, and has been influential in discussions on cultural competence.

Today, the term cultural competence continues to pervade writings in health, education, business and many other spheres and it has either replaced and/or

assumed a position alongside terms such as multiculturalism, equal opportunity, cultural sensitivity and diversity, all of which aim to address an underlying theme of attending to difference and equality as it pertains to human beings. Although these terms have overlapped, their underlying themes attempt to address similar areas of discrimination and perceived differences across societal structures as a means of gaining equality in outcomes for those concerned.

In these early writings on intercultural competence, Prichman (1965) identified a theme which continues to hold resonance with current writers on the topic. He postulated that in order to be equipped for intercultural business, a businessman needs to know about culture which he identified as a unifying concept which makes specifics fall into place. Interestingly, although he was writing from a business perspective, he identified the need for educational objectives. He stated that these should make conscious the nature of culture-bound behaviour, without which he warned, could present hazards when different cultures met. It appears that while Prichman's concerns regarding educational objectives were noble, the approach to cultural competence appeared to be aimed at preventing business men making faux pas in more serious and important matters and suffering 'culture shock' rather than in developing meaningful reciprocal communication in the achievement of negotiated and just outcomes for all those affected by transactions in business.

Multiculturalism

Beyond the early 1960's within the UK, the term cultural competence did not appear to gain in popularity; instead the term 'multiculturalism' was adopted as an approach to address inequity in educational and medical spheres. Influences on the development of these terms and other approaches for addressing inequalities were influenced by legislation such as the Race Relations Act 1976, the Sex Discrimination Act 1975 and the 1995 Disability Discrimination Act. As in attempting to find definitions of cultural competence, attempting to find definitions of multiculturalism also appears to be as elusive. Parekh (2000) identified that its central principles are not evident in a coherent philosophical statement. Similarly, Rex and Singh (2003) would argue that no one theory exists for defining it; however, there is some agreement in writings on multiculturalism that it is an umbrella term which supports or accommodates non-dominant ethnocultural and minority groups (Kymlicka, 2007) and that it advocates minority rights assimilation and accommodates diversity, a notion which is not dissimilar to that of cultural competence.

It has also been said that multiculturalism has created confusion in addressing racism, antiracism and inequalities in society (Berman and Paradies, 2010). Historically, multiculturalism has strong links to race and racism and it is often linked to concepts which address disadvantage, inequality and antiracism. Within health care, multiculturalism appears to have assumed less attention than it has in local government within the UK, although in health care education its presence has been evident (Graham, 2005; Bagnardi et al, 2009). The tenets of

multiculturalism appear not to have been spelt out in the form of competencies but like cultural competence, its development and philosophical principles allude to an underpinning issue of egalitarianism.

Equality of opportunity

Similarly, although the relevant issues contained within legislation refer to different types of inequalities, a tone of 'equal opportunity' was also becoming increasingly pervasive and this was strongly centred on race and ethnicity. Health research and policy development during the 1980s gave major considerations to subjects of gender and race, and equal opportunity policies in health care, including physiotherapy, were established across the majority of Health Authorities within England. Further influences on this term stemmed from a wave of migration of peoples from the New Commonwealth to the UK in the 1950s and 60s, the effects of which were to highlight further aspects of inequality. Like cultural competence, equal opportunity or equality of opportunity (a more recent revision of the term) is viewed as a concept also in line with the philosophy of egalitarian justice. Conditions which are shown to be unequal (different), may not necessarily be inequitable (disadvantageous). Likewise, conditions which are inequitable might not be unequal. Understanding and applying these notions has continued to challenge practitioners as evidenced in arguments surrounding positive action (Archibong et al, 2006).

A typology of equal opportunity presented by Liff (1995) identifies concepts of dissolving, accommodating, utilising and valuing difference as the prevailing

notions, and equal opportunity as an approach has been adopted in empirical research in seeking equity in health (Rosa, 2007). Despite this increasing momentum in the development of these policies, problems of inequality in health care continued to prevail throughout the coming years. These were identified in two influential reports by Sir Douglas Black (DH, 1980) and Sir Donald Acheson (DH, 1998). Their reports were strong, influential guides in the development of health care and equal opportunity policies within the NHS. Further changes from the rhetoric from earlier years of 'equal opportunity' for all, to one of 'equality in opportunities' has highlighted the approach by government to establish measures which not only identify differences in an increasingly positive way but also ensure that services are developed which address the factors fuelling inequality. Changes to the Disability Discrimination Act (1995) and its associated Disability Discrimination Amendment Act (2005), the Race Relations Act (1976) and the Race Relations Amendment Acts (2000) where public duties have been itemised in their amendments are indications of this change.

Diversity

Over many years, recognition of the lack of movement and success in addressing inequalities in health, education and the workplace has led to growing disquiet and pressure to change the emphasis from merely recognising difference and treating everyone the same to 'recognizing and valuing difference' and 'celebrating diversity' (Audit Commission, 2002). In the mid 2000s, the business case for celebrating diversity was being strengthened as a way of emphasising the recognition of individual differences and the benefits that this could bring to an

organisation. However, criticisms of the business case and its relation to ‘equality of opportunity’ were being made by individuals such as Bajawa et al (2006). Although the warnings were not directed specifically at health care, assumptions made in viewing the NHS as a business were similar. For example, assumptions that the NHS provided a stable working environment, that there were prospects of continuity in employment, career development and that individuals were enabled to engage in dialogue with the organisation were discussed as areas of possible contention.

The term ‘diversity’ is one of the most commonly featured terms adopted by the NHS and it has strong advocates in the academic, business and health sectors, but Johns (2004) suggests that it still requires careful articulation. The celebration of diversity has been credited with changing the views which society hold on a number of issues, in particular, race relations, disability awareness and attitudes to sexual orientation. The current political climate suggests that individuals may be enticed into the workplace by demonstrating that people are valued and that the organisation is seen to be diverse (NHS Scotland, 2012). It is probably the case that organisations that carry a label which ‘celebrates diversity’ as a function are more easily understood than ones described as being culturally competent. However, the term ‘diversity’ brings with it its own limitations and critics. Ross and Schneider (1992) are sympathetic with the view that by accounting for differences through adopting diversity management, the potential exists to trivialise systemic sources of disadvantage and ignore power differentials that are present. Gagnon and Cornelius (2002) are of the view that organisations should identify the choices

people have, enable the individual to make choices and create an environment in which they are able to make the fullest use of their capabilities, and that in this rhetoric, this individual choice could in turn benefit the organisation. However, for many establishments including the NHS, tensions often arise when attempts are made to achieve the optimum balance between enabling the individual and achieving organisational outcomes. If notions of 'profitability' or 'value for money' and long-term sustainability are to be major outcome measures for the NHS where there are strong social and moral decisions to be made regarding health care, then individual choices may be limited and this balance might be difficult to achieve.

Cultural sensitivity

A term which is often used interchangeably with cultural competence is 'cultural sensitivity'. It is defined by Ridley et al (1994) as:

> …perceptual systems that are geared to process many types of information and that are not limited to cognitive inputs. These inputs include affect, physiological responses, overt behaviours, language, spirituality, thoughts and beliefs, appearance, traditions, motivation, customs, rituals, and other aspects of the sociocultural environment (Ridley et al, p.129).

This definition is derived from the realms of psychological counselling, and draws together some of the less tangible elements which is encompassed within it. Cultural sensitivity continues to be the term which is often cited in health care literature but one where there appears to be limited evaluation (Connell et al, 2008).

In a theoretical analysis of the definitions offered above, it would seem that the three terms, multiculturalism, equal opportunity and cultural sensitivity can be differentiated and that there should be relatively little confusion in their understanding. However, whilst theoretical considerations may differentiate the concepts, in practice they are often used interchangeably. If they are aligned with the term cultural competence, then they would seem to have the same aim in mind, egalitarianism. The implications of this are that explicating theoretical meaning may offer clarity and although the three terms may be theoretically distinct, in practice this distinction may be of lesser importance for the practitioner.

Underlying themes in cultural competence – discrimination and prejudice

A fundamental principle which appears to be an integral part of cultural competence and other terms which have been adopted in the past is the ability to effectively manage inequalities not only in health care but in society in general. Influences on access to health care systems, and as a consequence the health status of individuals, include economic, social, political and environmental factors which are known to favour the better off (Taylor and Marandi, 2008). The underlying theme of egalitarianism in approaches to health care is also threatened by additional factors of prejudice and discrimination which have been identified as compounding and increasing levels of inequality in certain situations (Bhopal, 2009; Clark, 2009). In relation to becoming culturally competent, Papadopoulos (2006) identifies the importance of recognising and challenging discrimination as an important element in the process. However, while both prejudice and discrimination have received emphasis as important elements within training

programmes, their learning and teaching have proved challenging (O'Shaughnessy and Tilki, 2007; Bednarz et al, 2010). Therefore, exploration of their meaning to inform the developments within the investigation was undertaken.

One of the first obstacles in attempting to analyse prejudice and discrimination is often the lack of conceptual clarity when the terms are first presented. Bastos et al (2010) present the view that due to this, in a number of studies, instruments of measurement may not have adequately covered the full discrimination construct, hence their reliability and validity is questionable.

Awareness of one's own prejudice is often viewed as one of the fundamental parts of cultural competence (Seeleman et al, 2009). The Oxford Dictionary (online) offers a number of definitions of prejudice including 'preconceived opinion that is not based on reason or actual experience' and 'unjust behaviour deriving from preconceived and unfounded opinions'. Since prejudice is seen to stem from a lack of knowledge which informs the basis for reasoning, it is reasonable to conclude that we all hold prejudices since we all lack knowledge to some degree. If prejudicial behaviour is to be assumed to be preconceived opinion requiring reason or actual experience, justification of prejudicial behaviour may be deemed appropriate when it is based on degrees of moral, religious, ethical and political reasoning. Therefore, an understanding of context in which reasoning occurs requires analysis. However, if we are to address practice effectively, a degree of caution is warranted in the use of this stance. Turiel (2007) is not too far removed from this vantage point when he identifies that in practical situations, development

of concepts of what is right may become subordinate to other social considerations. Thornicroft et al (2007) also stress the importance of confronting prejudice which they suggest may be a greater predictor of discrimination than stereotyping with which it is often associated.

Closely linked to prejudice is the notion of unconscious bias where, in the absence of overt prejudicial attitudes, unconscious bias may still be present (Stuber et al, 2008). This relationship of discrimination and prejudice and their association within culturally competent practices has received limited attention within the literature, but on occasions authors have alluded to them in factors affecting its development. Consequently, there is limited evidence from which to assess it and from which to analyse associated behavioural skills and communication strategies in this area and their relationship to cultural competence.

Prejudice and discrimination promotes the development of negative relations between groups; therefore, how they are managed in developing cultural competence becomes crucial. Methods for reducing and combating prejudice have been forwarded by various writers including those of Wright and Lubensky (2008) who suggest the use of reducing prejudice and collective action frameworks to address the issues. Prejudice reduction is viewed as a mechanism for decreasing negative intergroup attitudes and stereotypes by changing the hearts and minds of the advantaged while the collective action framework focuses on promoting a collective awareness of and resistance to institutionalised forms of injustice which are centred mainly on the constructs of historically disadvantaged groups. There

has been relatively less research in the latter (Dixon et al, 2010) and the implications in developing cultural competence could be significant. A majority of the studies have investigated cultural competence from a prejudice reduction perspective including many of the studies which have utilised the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals – Revised (IAPCC-R) as a tool. The question which arises is whether this tool is in need of further revision.

Discrimination assumes a number of definitions with varying connotations ranging from bigotry and intolerance to discernment and judgement. When reference is made to issues of equality, the assumption is often made that it is the former of these definitions which are being alluded to and this is often the reality. Discrimination is referred to by Bastos et al, (2010) as a process by which socially defined groups or members are treated differently and/or unfairly because of their group membership. This definition assumes that discrimination affects groups as opposed to individuals. The view is forwarded that discrimination can pertain to anyone (rather than just groups) who might be perceived as different where negative behaviours are shown towards them. Within the notion of cultural competence, prejudice and discrimination are often cited as important contents in areas dealing with 'attitude/awareness' (Watts et al, 2008), but differentiation of its existence in groups or individuals as health care professionals and/or service users has been underexplored and dealing with sensitivities has proved challenging (Bednarz et al, 2010). It is also suggested that there exists limited analysis within the literature of strategies to tackle prejudicial and discriminatory

behaviours in developing cultural competence in learning and teaching within health care education, even though the term ‘discrimination’ has been embodied in equality legislation in the UK for some time. It is viewed as unacceptable and a ‘zero tolerance’ approach is often cited as a way of dealing with the problem. Zero tolerance was an approach forwarded in the 1990s and adopted within the NHS and by proponents of diversity as a means of supporting and protecting staff dealing with discrimination and violence. It is an approach which is often adopted for dealing with issues such as prejudice and discrimination in health care and it is a notion which may be worthy of discussion alongside professional codes of conduct and professionalism in the learning and teaching of cultural competence.

2.3 Cultural competence and professionalism

Like many of the other health care professions, the expressed relationship of professionalism in physiotherapy and cultural competence has received limited exploration in the literature and therefore any relationship is left to conjecture. For this reason amongst others, it is my view that it is important to explore and analyse this relationship and its potential influence in the professional development of undergraduate physiotherapists.

Professionalism has been investigated and reported from the perspective of peers and to a more limited extent, from the perspective of service users. However, from both perspectives, professionalism is becomingly increasingly recognised as a core competence in undergraduates (Hawkins et al, 2009). Increasing recognition indicates that one needs to consider the inherent attributes of professionalism and

how these should be addressed in the health care professions generally. Rogers and Ballantyne (2010) suggest that professionalism may be distinguished as both aspirational virtues/values and specific as observed in identified behaviours. These behaviours are deemed to include responsibility, relationship and respect for patients, probity and honesty, self-awareness and capacity for reflection, collaboration and team work and care of colleagues. It is not clear that the behaviours addressed in this approach which relate to medical education could be applied directly to other professionals in health care, and more specifically physiotherapy. However, the American Physical Therapy Association (APTA) state the core values of physical therapy as accountability, altruism, compassion and caring, excellence, integrity, professional duty and social responsibility (APTA, 2004). These are stated as values as opposed to behaviours and appear to be different to those expressed by Rogers and Ballantyne (2010) for medicine. Nonetheless, the expressed values of APTA are similar to seven core values published by the American Board of Internal Medicine (2001) with professional duty and social responsibility being the exception.

More recently, further differences in attributes of professionalism within physiotherapy have been suggested by Gersh (2008). The main behaviours identified were purported to be genuine reflective listening and responding, caring, trust, respect for individual differences, advocacy and empowerment of clients as 'first among equals'. Unlike Rogers and Ballantyne (2010), professional excellence was explicitly identified as one of the main features in the professionalism of physical therapists. Although Gersch's study was conducted with only 12 in-depth

interviews from clients who recently completed physical therapy, the attributes reflect the ability of the physiotherapist to engage in close and intimate professional communication with their clients, in verbal, non-verbal and practical ways. It is suggested that in identifying professionalism as respecting individual differences, advocacy and empowerment in the behaviours of physiotherapists, that cultural competence is implicit in these behaviours and its relation to the development of professionalism requires further attention. This study offered opportunity to explore some of the issues.

Richardson (1999) investigated two cohorts in undergraduate physiotherapy and their developing views of their profession. As well as identifying lack of clarity of goals and professional purpose, part of the conclusion was that undergraduate education is strongly influential on the formation and development of a professional paradigm. While the report concluded that challenging physiotherapy practitioners to ‘a cognitive disposition’ to pursue practice goals, it also identified the remaining challenges in formulating ‘a convergent knowledge base’ and converting it into professional services which fit the client. With this purported strength of the undergraduate curriculum to influence the development of a professional paradigm for students which aims to achieve positive outcomes for users, I forward the view that in developing professionalism, cultural competence should be considered as an integral part of all professional health programmes. The problem which exists is that cultural competence remains an unrecognised aspect of professionalism and even where competencies associated with the term might exist, assessment of it may be difficult because it is covert.

Specific versus generalist approaches in the learning and teaching of cultural competence

Proponents of cultural competence argue about the adoption of specific approaches as opposed to a generalist approach in the study of cultural competence and this raises implications for learning and teaching and for practice. For example, if students are required to practice in settings where the issues of race, colour and ethnicity have been shown to have a major impact on the health care of particular groups, to what extent should these issues assume a priority in the teaching of the topic within the curriculum? Lister (1999) suggests that a generalist approach could encompass all of these issues and is reluctant to single out particular groups for attention. Papadopoulos (2006) suggests moving from culture-generic to culture-specific competencies. This is in recognition of the fact that it is impossible to learn about all cultural groups but that gathering generic competencies facilitates the move to developing more specific ones. Cuellar et al (2008) presented a 'Blueprint for Integration of Cultural Competence in the Curriculum' (BICCC) for an undergraduate nursing curriculum as a framework for the teaching of cultural competence and this would seem to also assume a more generalist approach.

In respect to the medical curricula, Seeleman et al (2009) suggest translating the abstract educational objectives of cultural competence and relating these to competencies underlying curricula. The suggestion made is that delivering high quality care relies on emphasising specific aspects of generic competencies.

However, problems may lie in deciphering the overlap between generic and specific competencies and in deciding where the emphasis should be.

The power-distance relationship, i.e. the degree to which different cultures encourage or maintain power and status differences between the interactors (Brockner et al, 2001), may be applied at any level including the delivery of culturally competent care. It is clear that an individual's desire to bring about a change in power-distance will be influenced by threats and/or advantages to be gained by that individual and to the self-defined cultural group to which that he or she belongs. The influence of the law, moral codes, professional codes of conduct, religion and personality are all factors that may influence the level of this desire to bring about change. Campinha-Bacote (2007) touches on this notion of cultural desire and the strong influence it can have on institutional approaches to developing cultural competence. Thus power-distance relationships may be an additional complexity requiring exploration not only between the health care practitioner and their clients but also within a national context and between the competing hierarchies.

Current views on cultural competence confirm that there are a number of different stances and visions of the topic which range from embedding the concept firmly within specific notions of race and ethnicity, to a less rigid position and generalist view of how individuals construct meaning and apply them in formulating understanding, identities and behaviours in situations where inequalities exist. In conducting this study, my view was to adopt the scope of the definition of cultural

competence offered by the USHHSOMH (2012) where behaviours, attitudes and policy could be examined in cross-cultural situations, and to adopt a culture-generic stance recognising that learning and teaching may later become more culture-specific. Cross-cultural situations apply to a number of wide-ranging contexts where age, religion, sexuality, gender, race and ethnicity and where numerous other categorisations could be defined as 'cultural'; therefore, the importance of offering scope for the learning and teaching of the topic where both general and specific understanding could be explored was important in developing the study. Keeping this in mind and the research explored, relevant educational and learning approaches were examined for the contribution they could make in the investigations.

Approaches to measuring cultural competence

Until recently, few researchers have tried to set measures for assessing levels of cultural competence. As Wertsch (1998) identified, there are many difficulties in trying to explicate human, institutional, historical and cultural influences within human interactions. Therefore, it is not surprising that in investigating the topic within the literature, current measures which address factors such as the existing readiness of the individual and/or the institution to address inequalities, desire to change, moral codes, religious persuasion, prejudices and community/peer/family pressures have generally remained covert. Similarly, psychological and emotional factors which could emanate from investigations such as the notions of 'blame', omissions in practice and associated sensitivities do not lend themselves readily to measurement. If appropriate outcome measures of cultural competence are to be

elicited from the interactions between therapist and patient, and patient and the institution then these factors require explicit analysis. A consideration which further complicates the picture relates to cultural relativism – the idea of one culture assuming superiority in judging the cultural practices of another group (Cook, 2006). Therefore, within these parameters where measurements of cultural competence are context bound and are not of themselves culture free, measurements taken may not be an actual reflection of the reality. This study did not set out to measure cultural competence but rather to gain insight into the perspective of the undergraduates on the topic; however, it is apparent from the literature that measures are as varied as the context in which they were developed and their reliability and validity are under scrutiny. The view of Spencer et al (2008) in 'Surveys of Cultural Competency in Health Professional Education: A Literature', confirmed the view that the manner in which assessment methods in cultural competency training in undergraduate health curricula was conducted was variable and that further investigations are required to address this.

In attempting to design, implement and derive principles for assessment in cultural competency in curricula, Lie (2009) presents 'The Tool for Assessing Cultural Competency Training' (TACCT) as a validated assessment tool to build cultural competency curricula. It contains 42 learning objectives covering six domains of learning in 'health disparities, community strategies, bias/stereotyping, communication skills specific to cross-cultural communication, use of interpreters and self-reflection/culture of medicine'. Consistent with some of the other tools and approaches adopted for measuring cultural competence, the tool shows a general

tendency to lay the emphasis on race and ethnicity. Hence, it compartmentalises the concept into a restricted area and limits reflections into overlapping cultures outside of these areas. However, more importantly, one of the main limitations of this tool is in its lack of specificity in measuring the achievement of students' learning objectives and in measuring patient outcomes. Nonetheless, it offers a shared vocabulary on a number of educational objectives which could be used internationally to aid construction of cross-cultural curricula.

In relation to practitioners in general, the 'Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals' (IAPCC) developed by Campinha-Bacote (2007) has been identified as a reliable tool (Gulas, 2005), and more recently a revised version, the IAPCC-R has been utilised in a number of studies. Kardong-Edgren (2007) used the instrument to assess the cultural competence of nursing faculty teaching in baccalaureate nursing programmes and the reliability of the IAPCC-R tool is purported to been supported by Campinha-Bacote (2007), Brathwaite, (2005) and Hunter and Krantz (2010). However, Capell et al (2008) questions the validity of this commonly used tool as a measure of the construct of cultural competence. When benchmarked against the construct of 'ethnocentricism', they question whether cultural competence is in fact a unique construct. They suggest proceeding with caution in using the tool in health care, since in the assessment of the patient related variables, the patient dimensions receive little consideration when they are compared to the numerous dimensions identified for consideration in practitioners.

Kumas-Tan et al (2007) summarise many of the current debates and problems associated with measuring cultural competence. In a systematic review of the literature which spans 20 years, they examined quantitative measures of cultural competence and support much of the evidence surrounding the problematic assumptions made in its use. They confirm that questions surround the reliability of many of the instruments since they rarely involved patients, were referenced against white, middle class, highly educated individuals but more crucially, that debates around meaning and components of cultural competence are still on-going. They suggest developing measures that assess cultural humility in addition to addressing the issue of 'inequality', and the importance of power relationships in bringing about change.

Paez, et al (2007) stated that no one instrument could be found within the literature which could be said to be reliable and valid in its measurement of cultural competence in different contexts. This still appears to be the case today. Additionally, a lack of patient/client perspective when measuring cultural competence has been cited (Sue, 2001). In an attempt to gain the elusive measure of the delivery of cultural competence from a client perspective, Costantino et al (2009) have captured the term 'cultural congruency' which juxtaposes cultural competency with minority clients' cultural needs. Cultural congruency was defined as the distance between the cultural competence characteristics of the health care organisation and the clients' perception of those elements. The measure was used in mental health services where a two-factor construct of cultural congruence was used to assess whether it could predict

treatment outcome directly and whether it could moderate it. The conclusion was that it could do both and that the distance between culturally competent health care and the perspective of these services from diverse clients' needs to be a focal point for care delivery.

In the systematic review identified previously, Pearson et al (2007) investigated self-administered instruments to measure cultural competence of health professionals between 1980 and 2003. Out of a total of 45 instruments identified, only 13 were reported to demonstrate both reliability and validity. A comprehensive array of cultural assessment tools is now available but the extent of their reliability and validity is unclear. They have been used in numerous ways and in varied settings without a comprehensive review being offered. Likewise, measuring cultural competence must proceed from a logical understanding of the concept i.e. determining its construct, developing a measurement procedure and determining who or what can be measured and inferences which may be drawn. Construct validity is a theoretical form of validity. Since there is no absolute way of knowing, unless there is an accepted understanding of the construct, inconsistent operational definitions will continue to be evident and remain ill-defined. In addition to measuring the cultural competence of the individual, a tool to assess the adherence to the standards of cultural competency by organisations has also been developed (LaVeist et al, 2008). It is suggested that improving the cultural competency of the organisation increases the likelihood of higher patient satisfaction scores and more positive health outcomes.

This study offered students the opportunity to examine the effectiveness of their work in cross-cultural settings as viewed from their own perspective and to investigate the skills they felt they required and needed to develop. The opportunity to explore how undergraduate physiotherapy curricula might construct and address issues of learning and teaching in cultural competence was therefore founded on current literature and ruminations based on data elicited by the students.

Relevant educational and learning theories

One of the aims in this research was to investigate implications for learning and teaching of cultural competence within an undergraduate physiotherapy programme. Approaches to learning and teaching in higher education vary with the subjects and topics taught but more importantly, are shaped by the required learning outcomes; therefore, the learning and teaching of cultural competence is no exception. However, there is limited guidance in the literature in relation to approaches adopted by others within physiotherapy.

The overall programme aim stated in the Student Handbook for students in this study was:

> To develop autonomous graduate physiotherapists motivated to respond to the needs of individuals and groups within society. They will have been required to undertake research and reflection, be able to evaluate current physiotherapy practice and take part in professional development across diverse and changing health care settings (University of Birmingham, 2002) p.13).

The autonomous, reflective practitioner who is able to work collaboratively is considered to be an asset in the workplace. Educational theories that underpin the

learning and teaching strategies and which are purported to give rise to autonomous and reflective graduates are varied and these may be considered in relation to the learning and teaching of cultural competence. Practitioners who are able to adjust to changes, demands and challenges through reflection might not only bring about positive changes in behaviour but develop the potential to contribute to professional practice. Schon (1983, 1987) recognised that the individual who was able to reflect both in action and on action might be able to develop the level and quality of their learning beyond the realms of those individuals who did not adopt this approach. The connection made by him between action scientific knowledge and pragmatic knowledge has long been recognised (Kinsella, 2010) and important differences between novices and experts in navigating the 'swamps' of professional practice. His proposed epistemology of practice highlighted the important interconnection between the practitioner knowledge generated through reflection in and on practice where they not only shape it but become a part of it. Recognising that professional knowledge should be viewed beyond technical rationality is intrinsic to his work.

Before Schon, Dewey (1933) espoused increasing awareness of one's attitudes, ideas and responsibilities, open mindedness in dealing with problematic situations and reflecting on these as central to reflective practice. Not only was reflective practice considered by both Schon and Dewey to be worthy, but this active deliberation is expressed as intentional rational thought. The artistry of professional practice where individuals deal with uncertainty and unique situations is supported by both of these authors but this could be compounded in learning or

developing the artistry of culturally competent practices by the novice practitioner. The literature support the uncertainty faced by practitioners in managing intercultural episodes and it is likely that in these situations ‘critical incidents’ become a feature. Encountering and making sense of different value systems, beliefs and lifestyles can present situations where skills of reflection can be usefully applied in critical encounters. Critiquing how one reacts, manages the incidents and ultimately uses them to inform future learning can offer evidence of development as a learner. Similarly, students who are enabled to develop strategies of independent study, including an ability to identify a problem and seek out strategies to address it, whilst recognising where there might be limitations, are prepared with the fundamental skills for becoming reflective practitioners (Lahteenmaki, 2005). Although reflection is considered to be a central component of physiotherapy teaching, ways in which reflection is adopted, the extent of facilitation required to raise levels of criticality and how it might be best integrated into physiotherapy curricula remains uncertain (Roche and Coote, 2008). Likewise, independent learning and problem-based learning were recognised approaches within the programme, but the literature is scant on the effectiveness of these approaches in the learning and teaching of cultural competence in undergraduate physiotherapy.

Andragogy, assumptions about how adults learn, recognises the need for autonomy in learning. However, creation of an appropriate learning environment in which its development is nurtured and the context in which the curriculum is delivered is the responsibility of developers of curricula. Students were familiar

with the ethos of the university where independent learning formed the basis of learning generally. Facilitation of the transition from teacher dependence to increasing independence in skills of decision making is a fundamental feature of the process. In so doing, addressing the interests and concerns of the learner involves being sensitive, flexible, democratic and employing strategies which increase motivation to learn (Marshall, 2008). Charging students with choice in relation to what is learnt and when and how it is learnt can be motivational but requires appropriate and adequate resources, support and realistic expectations. Mastery of independent study can increase self-confidence, an attribute that contributes to personal, social as well as professional growth. These are factors which underpinned preparation for some of the student learning and teaching within this study but again, the literature offers limited documentation of the impact of these factors within the context of learning and teaching cultural competence in undergraduate physiotherapy curricula.

Experiential learning is recognised as one of the most effective ways for novices to develop skills relevant to the professional practice (Ryan and Higgs, 2008). Its relevance in learning and teaching cultural competence is encapsulated by writers such as Campinha-Bacote (2007) who identify the ‘cultural encounter’ and ‘immersion’ as important ways in which individuals might develop it. Built on six propositions Kolb and Kolb (2005) outline a précis of learning as process, relearning, resolution of conflicts, a holistic process of adapting to the world, results from synergetic transactions between person and environment and a process of creating knowledge. They emphasise that experiential learners must

own and value their experience for effective learning to take place and effective teachers should build on and explore what students already know. Experiences in cultural competence may present discomfort and challenges to the learner but as Kolb identifies, to learn requires 'facing and embracing differences' on a number of levels whether it is in challenges to belief and ideas, between novice and expert performance or otherwise. However, Kegan (1994) notes that the level of support often required by the learner may not always be available even when institutions have been successful in challenging students. Availability of resources and the extent to which students in this study felt supported was explored with this in mind.

Experiential learning can take place in a number of different settings, for example the work-place, internship or be project-based. Rogers and Freiberg (1994) encapsulation of the importance of applied knowledge to practice and Kolb's (1984) experiential model of concrete experience, reflective observation and abstract conceptualisation to active experimentation have been major contributors in portraying the nature of student experience. They describe learning where students are first immersed in the immediacy of events requiring them to reflect and develop a degree of impartiality within the context. Development of individual rationalisation, contemplation and integration of learning into a theory or a concept takes place and in turn gives way to testing of the new theory in new learning experiences. Commonly, analysis of critical incidents is used to actively engage learners in the process. The clinical placements undertaken by the students were considered to be akin to the work-based learning described by Kolb (1984) and

reflections within them provided a basis from which student experiences within them could inform the study.

The extent to which professional development may be moulded by learning and teaching strategies within the workplace has been alluded to above. In addition, knowledge, skills and attitudes which stem from these approaches might facilitate not only professional socialisation but socialisation as a life skill in general. Undergraduate physiotherapists are required to spend approximately one third of the programme in clinical practice and yet the influences of this socialisation remains relatively unexplored. Hodge et al (2011) offer the view that practice-based learning both produces and is produced by shifts in the way students understand the world i.e. in and through place and it need not be achieved through others, thereby suggesting that the environment itself is a contributory factor. In experiential learning, the expectation is that students are presented with opportunity for collaborative interactions in a safe environment with responsibility for reflection and experimentation shared with the clinician who assumes multidimensional roles including managing patients, students and administration. However, professional development of the students can be threatened by power relationship which hinder participation and create barriers to the development of positive learning experiences (Wenger, 1998). Student interactions with practice supervisors in the teaching and learning of cultural competence pose unique challenges of their own (O'Shaughnessy, 2007). Bandura (1990) also identified that there may be reciprocal interaction between external stimuli or environment and internal cognition where environment causes behaviour and vice versa. It is

important to recognise that one of the most important ways that a learner develops skills is in observing and reproducing the behaviours observed and that cultural practices and adjustments made are open to interpretation. It was assumed that insight gained from students of their experiences in the workplace might shape their perspective of cultural competence and inform future learning and teaching strategies suited to their needs.

Reflection

In conducting research, awareness of the researcher's own learning and thinking process, often referred to as metacognition, requires expression. I was aware that in seeking to explore the learning and teaching of cultural competence that along with the students I too was on a journey of discovery, not least because the topic had received limited attention within the curriculum in the past. My initial hesitation in researching the topic is highlighted in the excerpt which follows. It was based on the evidence which identified that BME staff are stereotypically found to be the leads on the teaching of diversity and ethnicity. As I recorded in my journal:

> I begin with a dilemma. I admit defeat in regards to attempting to steer clear of the 'race issue'. However I have found consolation, to some degree in some of the literature, e.g. Raj Bhopal [who] highlights the great need to address the question 'What actions could effectively reverse health and health care inequality?

As a black, female lecturer, I had to ask myself the question, 'Without attempting to try and influence learning and teaching of the topic, would I be playing my part?' I

was aware that socio-political, religious and other world views held by me, other staff and students were influential in the dynamics of the interpersonal relationships which operated in the environment in which I worked. I postulated that skills seen in clinical reasoning that I hoped I had developed over time, such as the speed at which expert practitioners can recognise patterns and formulate hypotheses and backward reasoning, would serve me well in my teaching and own learning. Therefore, I assumed, rightly or wrongly, at the start of the study that I had the experience and ability to manage some of the potential challenges. I had to accept that there would be some degree of unpredictability in the nature of the discourses and the extent to which the sharing of attitudes and beliefs including my own could impact on the professional and interpersonal dynamics which I had already developed with the students. I felt ready for this unpredictability and took support from literature which showed me that I was not alone whilst simultaneously recognising conflicting opinions and varied priorities of other staff. Curriculum development had been a feature of my previous work and I had become increasingly interested in exploration and development of craft knowledge. I think the excitement of doing something which I felt was worthwhile fuelled my enthusiasm to continue.

2.4 Purpose and significance of the study

The intention in pursing this study was to examine more closely the concept of cultural competence as identified by the literature and its perception by undergraduate physiotherapy students in order to inform learning and teaching in an undergraduate programme. There appears to be no formalised view emanating

from central government through the Department for Innovation, Universities and Skills (DIUS) to guide the inclusion of a coherent body of knowledge in undergraduate health care education. Neither does there appear to be consistent guidance on the topic from regulators of the physiotherapy profession, the HPC and its professional body, the CSP. The remit on the topic from the Quality Assurance Agency (QAA) is also unclear. Whilst many programmes incorporate the learning and teaching of subjects associated with the concept, they are normally individually tailored and so the learning outcomes appear to be inconsistent across programmes. Although programmes exist abroad, they may not fit or translate effectively into a different learning and teaching context within the UK. Staff and students have voiced concern over this lack of guidance (O'Shaughnessy and Tilki, 2007).

Of even greater concern are the ongoing directives from the government which identify that the patient or client's voice is central to developing their effective health care, yet their voices have had limited exploration within the ruminations (DH, 2009). If educators and practitioners remain unsure of what to teach and how to practice, then users of their services have less chance of being able to place their voice at the centre of the discussions. Although appropriate resources may be becoming increasingly available, there is limited evidence that they are readily accessible or that they are being used in the most efficient and effective ways to bring about improvement in the health care. For example, although interpreters and advocates may be widely available, practitioners may lack the appropriate skills required to incorporate them into their working practices.

The first key principle of the NHS constitution states that the NHS

> …has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population (DH, 2009, p.3).

An additional key principle is that it 'must reflect the needs and preferences of patients, their families and their carers'. It includes the need for practitioners not only to engage with their patients effectively, but for them to enable their patients to identify their roles and responsibilities within their own health care. The extent to which patients may be enabled to do this may depend on the cultural competence of the practitioner. The development of cultural competence provides the means through which practitioners and health care services may be able to demonstrate the appropriate skills and strategies required to promote equality within the NHS. Hence, the fundamental purpose of the study was to understand how undergraduate physiotherapists perceived cultural competence and to explore the implication for learning and teaching of the topic.

CHAPTER 3 METHODOLOGY

In this chapter, consideration is given to the theory underpinning the research methodology. It provides context for the processes including development of the research method, data collection, approaches to sampling, analysis and interpretation of findings. Discussions are offered regarding the adoption of a mixed methods case study approach.

3.1 Methodological considerations

Methodological challenges are well evidenced in research. In relation to the study of cultural competence, these have been noted in the US by the Agency for Healthcare Research and Quality (AHRQ) where a lack of definitions, interventions and standardised evaluative measures has been identified. It was anticipated that a mixed methods case study approach could assist in addressing some of the criticisms directed at positivistic approaches, such as the slow development of instruments for measuring it and the difficulties in acquiring large samples. In the report ‘Setting the Agenda for Research on Cultural Competence in Health Care’ (USHHSOMH, 2012) particular areas of concern were identified in the ‘content’ and ‘form’ of training.

Within the UK, methodological challenges in researching cultural competence have been less well documented, except perhaps in nursing. Here, progress has been made based on research emanating from a number of theoretical

perspectives. Methodological approaches rooted in anthropology have been used by Leininger and McFarland (2002), Purnell and Paulanka (2008), Meleis (1996), Campinha-Bacote (2003) and Giger and Davidhizar (2002). Mahoney and Engebretson (2000) place cultural competence firmly within contextual, experiential and pragmatic domains that incorporate interpersonal aspects of nursing care. Others such as Duffy (2001) adopt a postmodernist stance which emphasises critical reflection. Duffy's approach is centred on the Cultural Negotiation model forwarded by Engebretson and Littleton (2001) and the Interface of Anthropology and Nursing model (IAN model) by Mahoney and Engebretson (2000), where holistic and active learning are the key components.

In psychology, Sue's (2001) multidimensional model of cultural competence incorporates three primary areas – racial and culture-specific attributes of competence, components of cultural competence and foci of cultural competence – and appears to fall within a constructivist approach in studying the topic. However, comparatively limited commentary or explanation of the epistemological position of these various studies has been offered. Whitley (2007) argues that cultural competence is embedded in postmodernism and multiculturalism; as a paradigm it seeks to celebrate, understand and perpetuate differences/particularities and argues that there should be strong resistance to standardisation. This mixture of paradigms, or frameworks, provided a rich background from which the investigations were contemplated but it also illustrates that cultural competence is a complex notion to investigate in terms of research

and that approaches from a number of epistemological and philosophical vantage points have been attempted.

Part of the focus of this study was on finding out the perceptions of cultural competence held by undergraduate physiotherapy students. By investigating these perceptions, it was hoped to uncover meaning from which relevant theory might emerge which could be used to inform development of undergraduate physiotherapy curricula on the topic. As Allan (2011) notes, the function of theory is to explain how things work or how things come into existence and that “theory is built out of assumptions, perspectives, concepts, definitions, and relationships” (p.11). The nature of the emerging theory can be as wide ranging as the behaviours and understandings from which it is generated.

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The study adopted a mixed methods research approach to the traditionally distinctly qualitative or quantitative research methods which have dominated these pursuits. However, against this dominance, a mixed methods approach has emerged which goes beyond the exclusivity of quantitative and qualitative approaches and offers an alternative and more convergent approach from which theory may also be derived within a pragmatist paradigm (Onwuegbuzie and Leech, 2005). It has been argued that it provides a ‘third’ way in research and that it is a design with philosophical assumptions which can be analysed at all levels in the research process (Teddlie and Tashakkori, 2009; Greene, 2008). It is this mixed methods approach that has informed and suited this study’s design. At the outset, it was anticipated that collection of data would include both qualitative and

quantitative methods over the lifetime of the investigation. [It is important to note at this juncture that this investigation was conceived initially within an action research framework but for reasons related to the validation of the undergraduate programme, adjustments were made to the methodology. These are explained later.]

Establishing a focus on finding solutions to a problem and valuing multiple perspectives in investigating the problems is the cornerstone of mixed methods research. Without undue reliance on methodological loyalty, mixed methods research offers both objective and socially constructed criteria to make sense of reality. There is a belief and acceptance that perhaps true reality can only be measured imperfectly. By adopting different approaches in the investigation, students were allowed to offer their own realities of their experience of an unfamiliar concept in different ways and to confirm or disconfirm findings from their experiences in an undergraduate programme to inform future developments in learning and teaching of the topic.

3.2 Mixed methods research

Denscombe (2008) suggests that there is strong philosophical foundation for recognising alternative research paradigms, such as mixed methods research, which are grounded in positivism, constructivism and pragmatism. Support in contemplating the relevance of mixed methods research as a paradigm was drawn from the belief that it offered a pluralistic stance from which data could be gathered. The growth and recognition of mixed methods research over the last 20

years has been noted as a way of addressing innovative research questions (Kettles et al, 2011). Creswell and Plano Clarke (2011) describe mixed methods research as both a research design with philosophical assumptions as well as a method of enquiry. They are of the opinion that worldviews or paradigms – such as positivism, constructivism, participatory or critical theory research (research influenced by political concerns, for example empowerment, marginalisation) and pragmatism – are not irrefutable. They offer a general philosophical orientation to research which may be combined or used individually. This view caters for pragmatism, an approach commonly associated with mixed methods. In developing mixed methods research, the researcher is required to be skilled in both quantitative and qualitative research. As a consequence, understanding of positivism, constructivism, critical theory research and pragmatism and their relevance to different aspects of mixed methods research study is required. All four worldviews vary on perspectives of ontology (nature of reality), epistemology (how knowledge is gained) and methodology (the process of research). The relevance of each of these worldviews to this study in the context of mixed methods research is considered in turn.

Ontology is concerned with existence and reality and assumptions about human nature, about society, relationships and truth. The ontological position of positivist research sits in contrast to the position of the constructivist and the pragmatist, where it is assumed that there is only one true reality which can be identified and measured. In isolation, this thinking appears to be inconsistent with complexities exhibited in people's cultural world. Whilst a positivist approach seeks to measure

units scientifically, adopting randomisation and aiming to demonstrate cause and effect outcomes, a constructivist or interpretative approach affirms that social relations and the constructions made by the researcher must be interpreted and that meaning and language are socially constructed. Constructivist research seeks to understand the lived experiences of individuals. It does not predefine the variables under investigation but seeks to investigate the complexities of emerging situations (which was a focus of this study). Since the constructivist approach assumes that reality is socially constructed, it also forms the basis of hermeneutics (historically, the interpretation of written text, typically scriptures; more broadly, the interpretation of human behaviour) and phenomenology (reality as perceived – the study of experience from the perspective of the individual (Bryman, 2004)). The study also utilised the approach of grounded theory as a way of interpreting aspects of the data.

Positivist research emphasises independence between the researcher and the researched by adopting standardised and rigorous procedures and assuming that the researcher can study participants without influencing them. Interpretivists on the other hand, ascertain that capturing dynamic interaction between researcher and participants within the research context is central (Ponterotto, 2005). Use of reflexive accounts are offered at varying points throughout the study in which I attempt to explore and explain elements of subjectivity and interplay between planned and unplanned interventions and occurrences within an interpretivist approach.

Strauss and Corbin (1990) describe the notion of grounded theory as a way of developing theory which is grounded in data which has been systematically collected. Although there may be variation in how it is portrayed and the epistemologies associated with it, common themes within it are that theory is emergent rather than predefined, theory emerges from data rather than vice versa, systematic data collection and data analysis precedes theory generation, patterns are implicit in the data and analysis is both inductive and deductive (Cohen and Manion, 2011). It utilises a process of coding whereby a name or label given to pieces of information that are assembled, disassembled and reassembled at different stages in order to explore similarities and differences across cases until eventually themes emerge and the analysis becomes more organised (Cohen and Manion, 2011).

Open, analytical, axial and selective coding are common strategies adopted in examining data. Where this process was adopted in the investigations, an open and analytical approach was used because groups of descriptive codes were drawn together to be analysed and interpreted. Data were built up using categories and codes through examination of meanings, feelings and actions and integrating codes until coding was seen to be complete. In axial coding, interrelationships are explored through the interlinking of categories and codes (which might include events behaviours, strategies etc.) around a central axis of codes, while selective coding seeks to identify a core code and identifies other codes to that core code. These two latter aspects were considered to be of less direct relevance to the data.

Pragmatism has been cited as the worldview or paradigm for mixed methods research (Tashakkori and Teddlie, 2003). It is a philosophy which alludes to the practical nature of reality and so permits use of different methods. Using multiple methods, it focuses on the use of 'what works' and the development of understanding about how one comes to know. The primary focus is the question asked rather than the methods (Creswell and Plano Clark, 2011); pragmatism assumes the research question is the most important determinant of the research design. The ontological position in pragmatism is that both singular and multiple realities exist and researchers test hypotheses and present multiple perspectives in examining it. Researchers collect data using methods that work to address the question and adopt multiple stances in so doing. The methodology is not solely deductive, inductive or participatory but combines a mix of approaches and both quantitative and qualitative methods. There is no forced choice between positivism and constructivism. Mixed methods research embraces different perspectives and so offers scope to investigate events, social processes, group behaviours and individual and subjective experiences where methods are eclectic. Creswell and Plano Clarke (2011) contend that a researcher's worldview might shift within a study, changing to suit different phases of a project; a mixed methods approach accommodates such shifts.

The position of critical theorists as one of the four worldviews often cited in research was considered because like constructivists, critical theorists advocate a reality which is constructed within a social-historical context (Ponterotto, 2005).

However, whilst interpretivist or constructivist research pursues understanding of subjects and their ontological position in construing their lived experiences (Saks and Allsop, 2007), critical theorists are interested in social change as it occurs in relation to social struggle, and in general use their research enquiry to emancipate oppressed groups. As a concept, the topic of the investigation 'cultural competence' could have ramifications in critical ideology, but it was decided that the identified aims and the emphasis of the study placed it, on balance, further into an interpretive paradigm. In addition, although critical theory researchers aim to understand the relationship between societal structures, ideological patterns of thought that constrain the human imagination and limit opportunities for confronting and changing unjust social systems, it was also felt that limitations of this investigation did not extend to this epistemological position. However, consideration was given to the argument that unlike a critical theorist approach, interpretative accounts might not fully cater for the inclusion of the complex social, political, economic, environmental, historical, structural and power relation influences on the individual. While mixed methods research allows for variation in approaches, in line with Saks and Allsop (2007), the conclusion reached was that the pragmatist but also the interpretivist paradigm adopted provided appropriate scope for evaluation of the main issues within the study.

3.3 Physiotherapy, pragmatism and mixed methods research

Pragmatism is well suited to physiotherapy practice because it is outcomes related, takes into account different practice styles (for example, those of manual therapists, psychomotor therapists and domiciliary or home care therapists) and

contexts of practice (Shaw et al, 2010). Shaw et al (2010) also identify that in developing epistemology in the physiotherapy profession, mixed methods research gives value to critical, interpretive and scientific paradigms in which to explore best practice. Edwards and Richardson (2008) also contend that practice epistemology of an individual may also be influential in their clinical decision-making process and that it should be considered from the position of these three different paradigms. Physiotherapy is said to include a multidimensional knowledge base which prioritises movement in the context of function, and where close collaboration with clients' lifestyles and communicating virtues of caring and commitment (Resnick and Jensen, 2003) are implicit.

The lack of consensus within the profession about the paradigm in which the profession is positioned (Norris and Allotey, 2008) would seem to be fuelling the adoption of the epistemological position of mixed methods research. Other suggestions for research into physiotherapy include use of 'detailed ethnographies' of physiotherapy practice in order to assist in clarifying the picture and context of practice. In contrast, positivist approaches have been used in the investigations relating to the application of techniques and modalities. Although these approaches contribute to the picture of physiotherapy practice, in some ways they seem to fail to capture fully its meaning i.e. how it is constructed or socially determined. Rauscher and Greenfield (2009) have advocated the use of mixed methods design in physical therapy because not only does it offer the therapist a means by which complex interventions in treatment may be understood within the context of disablement, rehabilitation and the recovery process, but also,

they argue, this approach serves to propel physical therapy research forward by stimulating new research questions. They see pragmatism as offering a strategy in developing optimal holistic care and suggest that it will allow research to inform education and empowerment in physiotherapy practice which does not fall neatly into either the positivist, constructivist or critical tradition. Furthermore, it is also becoming increasingly evident that funding bodies actively seek the inclusion of qualitative elements in funding health research and that combinations of research designs and approaches are encouraged (NHS National Institute for Health Research, 2012). The Registered Nurses Association of Ontario (RNAO) identifies that whilst randomised controlled trials might be the most desired design for research concerned with causal relationships, they are the least desired when experiences of individuals are the focus of the investigation. Thus, mixed methods research in health education offers a way of investigating the complexities of learning and teaching and the interactions of people in normal everyday educational and clinical settings and it is perhaps particularly well suited to the discipline of physiotherapy.

3.4 Case study research

Pragmatism as a feature of mixed methods research allowed for the adoption of a case study and this variant in mixed methods research is a recognised hybrid in an embedded design. Here, the case becomes a placeholder for collecting the different types of data (Creswell and Plano Clark, 2011). Discussions surrounding case study research also pertain to case study within mixed methods research. Both can be viewed from a number of philosophical perspectives, in particular,

positivist, interpretive and critical theorist. As recognised by Creswell and Plano Clarke (2011) mixed methods research allows for the adoption of established qualitative and quantitative methods and criteria for their evaluation remain similar. The case study offered a view of reality and insight into wider practices as a basis from which theory could be developed. In addition, it offered a platform on which to summarise the narrative of complex human problems, and presented a case which had the potential to offer a 'wider resonance' beyond itself (Silverman, 2006). Tellis (1997) argues that following the methods put forward by researchers such as Stake (1995) and Bergen and White (2000), the approach may be as well developed and tested as those in the scientific field. The intention was to conduct a holistic and in-depth investigation with rigour over the period of the student journey through the course. Although case studies may be exploratory, revelatory, representative, explanatory or descriptive (Yin, 2004), a revelatory approach was taken since it was thought that it might help to identify questions and types of measurement that might be taken if a larger study were to be adopted in the future. It offered the opportunity to identify what could be learned within a specific setting, even though the issues being investigated were considered to be more widespread. Additionally, it allowed access to a situation not easily accessible to scientific observation and where the information exposed could be viewed as revelatory.

Yin (1984) defined case study as

> An empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon

> and context are not clearly evident; and in which multiple sources of evidence are used (p.23).

The notion of cultural competence has been inconsistently identified in the curricula of undergraduates within the UK and its importance in physiotherapy curricula has grown on a global scale. The revelatory case study, an approach which flourishes in social studies, facilitated exploration of the concept of cultural competence, relative to personal qualities, experiences and values which are considered to be core in the development of health care professionals. As with many case studies it was conducted on a small scale with a cohort of forty five undergraduate physiotherapists, at relatively little financial cost focusing on the circumstances, complexity and dynamics of a given case. It used multiple research methods to explore and investigate social settings which varied in degrees of complexity. It was envisaged that it could be an important and recognised research approach which could be used to generate theory and where the aim was to gain understanding of a selected case.

In recognition of increasing complexities in health care and the widespread use of case studies in nursing research, Anthony and Jack (2009) conducted an integrative review which critically analysed the contemporary use of qualitative case study methodology in nursing. Forty-two studies from 2005 to 2007 found on popular databases including CINAHL, Medline and EMBASE met the inclusion criteria for analysis. The conclusion which they reached stated that the growth in use of the approach warranted continued appraisal to promote a ‘well accepted

methodology' in the nursing research lexicon. However, the authors reinforced the importance of giving attention to case study elements and to the process. Methodological quality, authenticity and visibility were cited as significant features in publication of the method.

Mixed methods case study in an embedded design

This study adopted one of six possible design categories of mixed methods research as described by Creswell and Plano Clark, (2011); an embedded design where collection and analysis of both quantitative and qualitative data were combined within a traditional qualitative design. Secondary collection and analysis of quantitative data were implemented within the larger design and provided a supportive secondary role in the study. A premise of this design was that a single dataset may not be sufficient to address the question and that different datasets might offer exploration as well as explanation. A variant of this embedded design is a mixed methods case study (Luck, Jackson and Usher, 2006) and the latter was the adopted approach in this study. Yin (2009) also identifies an embedded single-case design where more than one unit of analysis is incorporated into the design.

Box 1 Examples of other prototypes of major designs – (adapted from Creswell and Plano Clarke (2011))

Convergent parallel – uses concurrent quantitative and qualitative data collection and analysis, then compares or relates them followed by interpretation. Adopted where there is need for a more complete understanding of the topic and to validate or corroborate quantitative measures.

Explanatory sequential – uses quantitative data collection and analysis followed up by qualitative data collection and analysis and interpretation. Used where there is a need to explain the quantitative results.

Exploratory sequential – begins with qualitative data collection followed by quantitative data collection and analysis to test or generalise initial findings.

Embedded – qualitative data collection and analysis or quantitative data collection and analysis are combined concurrently or sequentially within a traditional quantitative or qualitative research design.

Transformative – uses a theoretical-based framework for advancing the needs of under-represented or marginalised populations e.g. feminism, disability.

Multiphase – goes beyond the basic designs and examines a problem through an iteration of sequentially aligned studies, each building on what was previously learned to address a central objective.

The core of mixed methods research is based on actions of the researcher i.e. rigorous and persuasive analyses of qualitative and quantitative data. These two datasets are integrated either concurrently or sequentially, giving priority to one or both forms of data depending on what the research wishes to emphasise. Qualitative and quantitative procedures are used in a single study or in multiple phases within a programme of study, where meaning is given to procedures within philosophical worldviews and theoretical knowledge, and procedures are combined into specific research designs (Creswell and Plano Clarke, 2011). Mixed methods research assists in addressing questions that neither quantitative nor qualitative approaches alone can effectively address and where use of multiple sources of data provide more evidence than a single method.

Mixed methods research designs may be considered to be fixed or emergent. In fixed methods research, quantitative and qualitative methods are pre-planned and

fixed at the start of the research while in emergent mixed methods design issues arise due to the development in conducting the research. This study adopted an emergent approach. Approaches to mixed methods research are continuing to evolve and so as well as fixed and emergent designs being recognised, Creswell and Plano Clark (2011) describe typology versus dynamic approaches. In a typology approach, the researcher is provided with a range of well-defined options for addressing the research problem whilst a dynamic approach considers and interrelates multiple components of research design rather than laying emphasis on designs which already exist, and offers greater scope in considering epistemology, theory, methods and analysis. It is suggested that as researchers gain more experience in mixed methods research, the dynamic approaches may be of value.

Emergent mixed methods designs arise due to issues that might develop during the process of conducting the research, or perhaps because one method is found to be inadequate. Within this study, issues arose within the course of the study which could have impacted on validation of the undergraduate programme and this meant that instead of pursuing an action research design within a qualitative paradigm, a case study approach was adopted. In mixed methods research, both fixed and emergent mixed methods designs are seen as end points along a continuum rather than standalone entities. Thus it was an approach in which this change in design could be accommodated.

Although there are advantages in adopting an embedded design, such as adding supplementary data to improve the larger design, there are some challenges. The researcher is required to specify purpose for collecting primary and secondary data and decide at what point to collect this data. In addition, it may be difficult to integrate results when two or more methods are used to address different questions. However, unlike a convergent design the researcher can keep results separate although this can bring its own challenges when interpretation and triangulation of the data becomes increasingly important. Criteria used for evaluating mixed methods research rely on established methods adopted in quantitative and qualitative research. Nevertheless, there is an ensuing debate regarding how criteria for evaluation are developed and established in mixed methods research to inform practice (Shaw et al, 2010).

Mixed research methods are reported at different levels in its depiction of methods, methodologies and paradigms in research (Creswell and Plano Clark 2011, Greene, 2008), see Box 1 and 2.

Box 2 Realms of Mixed Research Methods (Creswell and Plano Clark, 2011)

1 Methods – quantitative and qualitative methods for the research and data types
2 Methodologies – mixed methods as distinct methodology that integrates world views, research questions, methods, inferences and conclusions
3 Paradigms – philosophical foundations, world views underpinning mixed methods research
4 Practice – mixed methods procedures in research designs

Further domains are also described by Greene (2008) (see Box 3 – Domains of mixed methods research) who sees mixed method as being implicit at all stages of the research processes.

Box 3 Domains of mixed methods research (Greene, 2008)

1 Philosophical assumptions and stances – assumptions about the nature of the world and how we understand and research the world
2 Enquiry logics – purposes and research questions, designs methodologies of research, sampling, data collection and analysis
3 Guidelines for practice – how to mix methods in empirical research and in the study of the phenomena
4 Socio-political commitment – what and whose interests and purposes are being served

The approach of mixed methods research as a methodology as described by Creswell and Plano Clark (2011) provided a focus for this study.

Sampling, data collection and interpreting findings in mixed methods research

In mixed methods research approaches to sampling pertain to both qualitative and quantitative approaches; however, the way in which they are addressed may differ. In qualitative research, purposeful sampling predominates but there may be variations in the strategy adopted, for example individuals may be purposively chosen because of the diverse views which they hold on a topic. In this study, first year undergraduates were chosen as the main subjects because as a new cohort, they were considered representative of a typical intake and it was assumed that they would present perspectives of cultural competence which might be typical of

such a group. In consequence, the sample size was determined by the annual intake of students. During the study, further sampling was undertaken, for example students chosen for their level of experience in working with minority groups for the interview group. This is unlike quantitative approaches to research where a probabilistic approach is adopted i.e. individuals are randomly chosen and have a known chance of being selected.

Overall, a sequential process in data collection was adopted rather than a concurrent one as it was considered that it aided clarity, and supported or illuminated findings in different phases in the study (Creswell and Plano Clarke (2011). Occasionally, both qualitative and quantitative data were collected in one investigation, as for example in the use of a questionnaire issued at the start of the study in order to obtain biographical data and to establish a platform for identifying individual experiences in learning and teaching. A group interview (see Chapter five) was introduced partly based on revelations from the initial questionnaire and to gain additional insight into student experiences. Data from the repertory grids offered students' perspectives of cultural competence through the use of constructs. These were viewed as being principally qualitative although quantitative data served to offer further information of students' competencies relative to each another. Perhaps more importantly, they offered an element of self-assessment in which students could rate their competencies relative to others offering this from their own perspective. Similarly, personal accounts served to illuminate student perspectives of cultural competence following external visits to

diverse communities. Further detail is offered in the appropriate chapters and in triangulation of the data in Chapter eight).

Integration of qualitative and quantitative in mixed methods research is an important factor affecting interpretation of the research and it is recognised that this should be made explicit. It may occur during data collection, results, analysis and interpretation phases. Merging of the processes may occur during interpretation or analysis; on the other hand, superimposing one design (qualitative or quantitative) within one or the other may be possible. Alternatively, a process of 'connecting' may be adopted, where qualitative leads to quantitative conclusions or vice versa. In this study, data were merged during interpretation and analysis. How, where and what was done with the data requires justification and these actions are followed up in Chapter eight in triangulation of the data and discussion in this section.

Criticisms of case study research

Criticisms of mixed methods research encompass those which are levelled at research generally. In respect of quantitative research, these include those related to generalisation, reliability and validity (for example, arising from small samples, or convenience sampling). Criticism related to qualitative methods includes those related to credibility, transferability, dependability and confirmability (Guba and Lincoln, 1994). These criteria relate to the trustworthiness of the research. Specific criticisms may be levelled at the assumptions made by the researcher that respondents' accounts are created rather than uncovered and that interpretation of

the data identifies the researcher's thinking rather than those of the informants. However, in its defence, when speaking of the case study in the context of social enquiry, Chima (2005) suggests that it offers analytical extrapolation of causal processes occurring in one case which might be used to explain a particular social phenomenon and offers opportunity to re-evaluate theories about the phenomenon. Since internal validity is dependent on the plausibility of the analysis and findings, he also puts forward the case for use of quasi-judicial and collegiate review as a way of determining internal and external validity of case study research. Stake (1995), like Silverman (2006), speaks of the data resonating experientially with readers and thereby facilitating greater understanding of the topic under investigation.

On the issue of generalisability, Yin (2004) refutes the criticism of case study research not being widely applicable to real life. He argues for acknowledgement of the difference between analytical generalisation and statistical generalisation. In the former, he suggests that previously developed theory can be used to compare empirical results stemming from a case study; whereas, in the latter, statistical generalisation assumes that some sample of cases have been drawn from a much larger universe of cases. Although numerous critics argue the generalisability of results from a case study, the latter has been used extensively in the literature as empirical investigation for contemporary phenomena. Bryman (2004) agrees with other writers that generalisability of case study is not the aim of case study research because of its dependence on a single case. Hamel et al (1993) offer the view that it is the goal of the study which should establish its parameters.

Since generalisations are often applied to theory and not to populations, and pattern matching can increase confidence in the robustness of the theory, in this study, further consideration was given to the eventual meaning of what could be attached to the study. National guidelines for the conduct of undergraduate courses are laid down by the CSP and although the programme under investigation could be considered as representative of UK courses, it was not assumed that the results could be extrapolated to other courses. However, the opinion that just as historically, single cases have been known to have major impact on organisational systems of care and have led to major changes in legislation (Gillham, 2000), an assumption was that case study can present a powerful argument which may help to re-evaluate theories about general phenomenon.

3.5 The study's emerging theme over time

At the outset, the study sought to explore the perception of cultural competence in undergraduate physiotherapists and implications for learning and teaching. At this point, as with much qualitative research, although the aim was clear, the question was not fixed (Thomas, 2010) and the approach was to contemplate what I needed to know and the best ways of finding that out i.e. How do undergraduate physiotherapists perceive cultural competence and what are the implications for learning and teaching the topic? Reasons for initially choosing action research as the preferred approach are offered below and included the fact that it allowed for the implementation of change in teaching and learning if the need arose. However,

when events dictated that certain changes could not be implemented within the curriculum without them affecting the validation of the programme, initial thoughts of conducting action research gave way to the adoption of a mixed methods case study as the main approach. Support for change in approach come from the writings of Yin (2004) and other researchers who recognise that an alteration in the methodology can and does occur in qualitative research. It has been shown that methodology is often strongly influenced by the research question and that some degree of flexibility in methodology may be required in pursuit of addressing the research question. Byrne (2001) also points out that in qualitative research, the methodology may be refined as the researcher begins data collection and gains new knowledge. Mixed methods research places the research question at the heart of the proceedings and recognises the importance of adopting methodologies best suited to addressing the question with due consideration given to pragmatism. Adopting a mixed methods case study approach to answer the question appears to fulfil this need. Given that the research began with action research in mind, discussions are offered here as it pertained to the study when it began.

Thoughts of action research

Action research enables the searching and development of knowledge within practice, and in so doing has been described as a 'situationally responsive methodology' by Cohen and Manion (2011, p.361). The intention was that there would be little disruption to the planned curriculum and where additional teaching was to be developed, it would be introduced only in the context that ensured that

the stated learning outcomes of the programme were still met. Therefore, in this light, it was thought that the action research strategy would facilitate the following:

- Exploration of cultural competence within a specific context with the researcher in situ;
- Exploration of cultural competence within an existing curriculum;
- Development of an approach where the control of certain variables were deemed inappropriate;
- Involvement and contribution of participants in the development of learning and teaching of the topic which reflected their individual preferences;
- Opportunity to contemplate/introduce change based on the lived experiences of the participants.

Further considerations of action research contributed to its adoption as a strategy at the start of this study. It is a method of enquiry that allows the practitioner to remain within the context of practice whilst in the pursuit of generating new knowledge to inform their work. Although it is viewed as practitioner research (McNiff et al, 1996), it can involve many people other than the researcher. A differentiation is often made between practitioner research and action research where the former is seen as research undertaken by practitioners on topics that relate to their professional interest, but does not examine practice as the prime purpose of the study. The latter is an examination of practice that occurs to enhance the experiences of learners. Since one of the intents was to enhance the

experiences of the students, an action research approach was deemed to be appropriate.

Akin to the main focus in mixed methods research, action research begins with the diagnosis of a problem. This is then followed by the setting of goals and strategies, the planning and selecting of appropriate strategies to achieve the goals and evaluation of the outcome of those strategies. A process of constant monitoring, reviewing and feedback at all stages is considered essential to the process. Therefore, the intention of the study was to follow a similar process.

Different ways have been used to demonstrate the 'spiralling' nature of the activities by which action research evolves. Two examples are Kurt Lewin's model as interpreted by Kemmis and McTaggart (1988) and the Griffiths and Lomax (1990) model. Kurt Lewin who is said to have first coined the term of action research, describes a circle of activities which includes a first stage of identifying an idea, then planning, execution and fact finding in order to feed into a third step which includes possible modification of the overall plan. The circle continues with evaluation and the taking of the first action step whereupon the circle may repeat itself. Griffiths and Lomax (1990) on the other hand recognise the basic tenets of action research in a perpetual reflecting, planning, acting, observing cycle but also suggest that there might be the potential for action research to enhance social justice, especially in educational practice. Implicit in the spiralling nature of action research is the inevitable final phase of the investigation which leaves the researcher with the next question to be explored. The researcher is allowed to

make changes to an original plan if the situation makes it more appropriate to do so. This flexibility offers a means by which best practice may be developed and the opportunity for the participants to make an open contribution to its evolution. It offered the researcher a means by which the dynamic nature of learning and teaching could be retained and new experiences introduced whilst being mindful of the criteria on which the programme had been validated.

Although the methods of investigation used in action research are eclectic and stem from both quantitative and qualitative research, action research runs counter to a positivistic approach which attempts to control all variables to demonstrate cause and effect. Instead, it relies on an interpretive approach that surveys the past and present situation in order to provide an explanation of the 'truth' (DePoy and Gitlin, 1998). It was therefore an apt framework in which to place this case study at the outset. The action researcher recognises that there are subjective and objective variables in any 'live' situation and seeks to give an explanation of the contribution of each of these to the field of study. The subjective opinions of all the participants, including those of the researcher, are entered into the evaluations undertaken, and a process of triangulation assesses their worth where different accounts are compared for differences, agreement and disagreement. Ensuing interpretations should rest on the pillars of 'truthfulness' of the results of action. Hence, the requirement to continually address the truthfulness of the processes and the results they yield is as pertinent as in quantitative approaches to research (Guba and Lincoln, 1994).

Action research is viewed as emancipatory, in that it is pre-disposed to the critique of ideology and places control over processes in the hands of those involved in the action. In adopting this approach, it was envisaged that opportunity for undergraduates to give their opinion freely was important in the way in which data were collected and obtained. This liberating view in action research has been expressed by a number of writers and an accompanying sense of ownership to the main participants should be implicit. The growth of action research as a valid research approach in a number of fields such as education is testimony to the position it holds in the debates centred on developing new knowledge (Kemmis and McTaggart 1988; Gorard and Taylor, 2004).

An additional strength of action research is that it examines developments in context as they happen and thus the research is intrinsic to the existing activities. A record of changing events is made available for scrutiny and the participants are given the opportunity to influence events as they occur. Although developments are context bound, the process may be used to inform strategic developments in other situations. The knowledge that stems from these real situations is often regarded as 'personal knowledge' i.e. it is gained through a spiral of reflection within the action researcher's own practice. This personal knowledge is not divorced from the interpretations of others and indeed is developed within an arena that demands the critical discourse of others. It embodies the values and interests of the observers and the participants. The intimacy the researcher has with the events that unfold, offers increased scope for engaging in a timely

manner. The powerful dynamics within a context such as this, offered a rich medium for discourse. However, therein lays the potential for criticism.

Criticisms of action research

Problems identified in action research include issues related to the surrounding theoretical, philosophical, personal, classroom, institutional and societal factors (Bottery, 1997). Criticisms are made regarding the generation of knowledge from practice where the validity of the theories generated is said not to rest on 'scientific' tests of truth but on their usefulness (Elliot, 1991). It could be contested that usefulness can generate truth. Even though positivist and interpretative approaches are able to take account of external constraints and distortions of the problem under investigation, unlike action research, they may not consistently provide ways of identifying and overcoming these in the context in which they are being investigated. Thus, in this vein, the intent of the knowledge generated leans more to transforming and influencing the present (Kemmis and McTaggart, 1988) and this was the avenue identified in which to place the study.

Developments can be messy and plans revised in response to the dynamic nature of the procedures and processes in action research, and these changes need to be taken into account in analysis and evaluation of the procedure. Difficulties may also be experienced in capturing the total reality of all the lived experiences. Hence the 'control' of procedures by the researcher may be construed as biased by outsiders if careful steps are not taken to ensure validity and reliability throughout the process. The way in which reliability and validity is often construed

in action research is somewhat different to its construction in quantitative approaches. The importance of the person's interpretations and the process by which events are managed by significant players are often seen as a good basis for establishing validity. This is in contrast to objective approaches which are sought in positivist or quantitative approaches (McNiff et al, 1996). However, Edwards and Talbot (1999) identify a major challenge where they see the process of personal and professional development for the researcher and efforts to encourage self-exposure in critical and reflective analysis in the research could be sabotaged because of institutional and organisational control measures. As explained, control measures were one of the main reasons for later adopting a mixed methods case study approach instead of a case study embedded in action research. It was considered that a mixed methods case study could offer a similar basis for considering and allowing the adoption of quantitative and qualitative strategies to explain the phenomena of students' perspective of cultural competence within the learning and teaching context of the programme.

3.6. Outline of approaches to data collection and points of method and data capture

In adopting a mixed methods case study, data collection in the study was varied. It was collected primarily through the use of questionnaires: an initial questionnaire (QT1) at the start of the study, issued again in year two (QT2) and a final one at the end of the programme. Data collection was also made through group interview, repertory grid technique, experiences with minority ethnic groups (MEGs) and personal accounts of learning and teaching in the IBR (Illness, Behaviour and

Research) and Clinical Studies module. The point at which data were captured is outlined in Table 1. How these investigations were implemented, analysed and interpreted is offered in the relevant sections. Reasoning behind the chosen investigations and their association with the progression of the students through the programme is also offered in those sections.

Data and findings will be presented according to the year in which they were collected (see Table 1) while triangulation of the data is given in Chapter eight.

Table 1 Points and methods of data capture

	Main data sets	*QT1 (n=45)*	*Group Interview (9)*	*Clinical experience with MEGs feedback (n=30)*	*Personal accounts (n=42)*	*Repertory grids (n=43)*	*Questionnaire QT2 (n=38)*	*End of year Questionnaire (n=9)*
1	*Questionnaire QT1*	*Year1*						
2	*Group Interview*		*Year1*					
4	*Clinical experience with MEGs feedback*			*Year2*				
5	*Personal accounts*				*Year2*			
3	*Repertory grids*					*Year 2*		
6	*Questionnaire QT2*						*Year2*	
7	*End of year Questionnaire*							*Year3*

CHAPTER 4 THE CASE

4.1 The researcher

Case study research in which the researcher is embedded requires that they must be aware of how their life experience influences the research. Greenbank (2003) suggests the need for a self-reflexive account although this is in itself is limited to the same partial perspective, inadequate memory, distortions, selectivity and other potential biases. However, it was my intention that the information offered should enable the reader to come to their own judgement about researcher influence in this study. My intention was to attempt to apply the same rigour in the self-reflexive accounts as was applied in the research.

I am a black, Afro-Caribbean female who was born in Jamaica and completed my secondary education in the UK. After training and practising as a state registered Chartered Physiotherapist in two major hospitals, I became a university lecturer in Birmingham. My interest in the topic of cultural competence stemmed from my personal experiences in working with diverse groups, but was more strongly influenced by my own challenges and those identified by students and staff in their clinical encounters with patients from minority groups in the inner city. Equally influential on my interest to undertake the study was the broad disparity in the demographics between the students with those of their patients i.e. differences in ethnicities, age, gender and socioeconomic status. As a lecturer and member of a 'caring profession', it seemed that there were common, yet fundamental problems in communication between students and certain patient groups although I also

found challenges in some of these communications. I was also aware of some of the sensitivities in the discussions of race, ethnicity and culture between the various groups of staff, students and clients which prevailed. Situated betwixt health and education, I felt suitably placed and sufficiently confident to begin to bring some of the issues and debates into the educational and professional spotlight.

Suspicions around the unease felt by the students and staff were vindicated when their concerns were openly endorsed and discussed by colleagues and in reflective writings of the students when they returned from working in different communities (Clifford et al, 1999). Certain students recognised that although the topic was sensitive in nature, the development of skills of students working with different minority groups required urgent attention. The Health Authority's endorsement of a project to investigate this concern regarding the cultural sensitivity of staff and students reinforced the view that the topic of cultural competence was worthy of further investigation (Clifford et al, 1999).

Within the study where interpretations have been offered, and in order to minimise or avoid bias, the reader is invited to impart their own critique. I recognise some issues may have been influential at varying times in both the responses of the students and the data collected, as well as in the interpretations offered in the study (Flick, 2009): my ethnicity; status as lecturer, researcher and Chartered and State Registered Physiotherapist; personal views and beliefs; as well as the modes of interaction which occurred; communications and the vibes transmitted as

a subconscious player. My personal interest in seeking life-long development of educational and clinical competencies when working across different cultures with staff, students, patients and the general population has long been a personal goal and has been influential in developing approaches to learning and teaching in my career. Thus, the overall aim of the research to explore student perceptions of cultural competence in order to inform ways of learning and teaching the topic in the undergraduate curriculum became an implicit part of my pedagogical goals.

When this study began and during its pursuit, as a starting point in introducing the topic into the curriculum, I adopted a tentative view that cultural competence related to meaning and behaviours that individuals and society attach to the context of lived experiences. Therefore, I viewed it as dynamic, responsive and unique to the individual and their context although some of the experiences and situations could be shared by similar players, for example in rituals and celebrations by invitation or imposition. In offering this starting point as a tentative and personal perceptual stance, I tried to retain flexibility and an open mind in understanding and in the teaching and learning of the topic. I expected my perceptions to be open to challenge, criticism and that they might change.

4.2 The subjects

The research adopted a mixed methods case study approach and so mimicked the convenience sampling described by Flick (2009). The main consideration was in identifying opportunities where clear tracking could be made of the cohort over the three years of their programme and ability to maintain contact with them over

that time. As a resident lecturer, access to the students was considered to be unproblematic although there were clear ethical considerations which are discussed later in this chapter.

In order to obtain a longitudinal view of the students' progression, the aim was to include students who were relatively new to the programme and whose learning and teaching could be followed over the duration of their study. The cohort of undergraduate physiotherapists was chosen and for reasons which will become clear, the investigation began in the second semester of the first year of their undergraduate programme. A biographical outline of the students is offered in Tables 2 and 3. The process by which these students were selected for the course was through the standardised procedure of the University. The entry criteria for the BSc (Hons) Physiotherapy programme are rigorous and personal statements are scrutinised for evidence of work experience in physiotherapy and all potential recruits undergo an individual interview. Historically, the course has been oversubscribed with over a thousand applicants competing for approximately forty five to fifty places. Candidates normally offer excellent grades of A and Bs both at A level and at GCSE level and these are often offered alongside a range of extracurricular activities. They are mainly students born in the UK, white, predominantly 18/19 years old and female; the students in the chosen cohort were similar to this profile on all counts.

Table 2 Biographical Details of the Subjects – Age

Age			
		Frequency	Percent
Valid	18	20	40.8
	19	20	40.8
	20	3	6.1
	24	2	4.1
	28	1	2.0
	35	1	2.0
	Total	47	95.9
Missing	System	2	4.1
Total		49	100.0

Data were unavailable for two of the subjects. One student left the course and the other joined the course belatedly from another cohort. However during the course of the study, through attrition, the final number of students was 45.

Table 3 Biographical Details of the Subjects – Gender

Gender	Frequency	Percent
F	43	87.8
M	6	12.2
Total	49	100.0

Further biographical details of the students are offered in Chapter four.

The majority of students achieved an average of AAB grades at A level, i.e. A level point scores of 320 or more. Where grades were unspecified or identified levels were below this average, students would have needed to demonstrate via other non-traditional qualifications, such as the international baccalaureate, access and HND qualifications, that they had reached the required academic level of achievement.

4.3 Ethical implications of the study

Approval to commence the investigations was given by the University. At that time, there was no requirement to submit a standardised form. However, approval for the investigation was gained based on its development from a previous study which had been approved by the Strategic Health Authority (SHA) in which I was one of the main investigators (see Clifford et al, 1999). Direct approval to continue the study as part of the developments which stemmed from the study using the original questionnaire was gained from the same research team (see Appendix 2). Further approval from the subjects was sought for each of the investigations whenever it could have been considered that an activity or intervention was 'different' to what might have been envisaged in the normal programme, and where these may have occurred, they are identified throughout the case study. There was no formal mechanism at that time by which to gain approval from the students for the three years of the study. Matching social developments with the curriculum as they arose was a challenge recognised in a letter to the Strategic Health Authority (SHA) (see Appendix 3).

Independent ethical scrutiny of research is recognised as a feature of research (Anderson and Pickering, 2008) and this was constantly under the auspices of the project supervisors. Considerations were made to health and safety and potential risk factors but these were not thought to be significantly different from those of the course requirements. Similarly, the legal requirements relating to conducting action research were considered to fall in line with those that existed for the course.

Adherence to best practice procedures in data collection, storage, management and protection was maintained throughout the study. Hard data were secured in a locked cabinet in a personal office while electronic data were stored on a single access personal computer. Contributions from all individuals involved were acknowledged. Even though the research was conducted some time before the publication guidelines in UK Research Integrity Office's Code of Practice for Research (2009), in retrospect, it followed many of the guidelines and was consistent with the guidelines which were present at the time.

Issues of informed consent and confidentiality were felt to be paramount in the pursuit of the investigation, especially in how the data were managed. Student feedback suggested that cultural competence and cultural sensitivity were topics which brought some discomfort but which they had felt required further development within the programme and they were very willing to offer their contribution. Nonetheless, care was taken to ensure that they were aware that the study formed part of a doctoral thesis and that data would be collected for that

purpose. Even though they were happy to offer their names on some of the data, they were reassured that no names would appear in any subsequent publication or in the public domain.

Respect for autonomy, beneficence (making things better for people), and non-maleficence (doing no harm), avoiding coercion and manipulation and empowering the students to make informed choices were goals set in pursuit of the study. The importance of ensuring that students were enabled to say no to any request for their data and to have individual data withdrawn was a mechanism which was built into all the investigations. For example, if a student had wished for their repertory grids to be withdrawn, this could have been done. However, although requests for withdrawal of their data from the results pool could have been made, the nature of case study research meant that they were inevitably involved in the normal learning and teaching of the topic throughout the course of the investigations. Methods adopted in gaining consent and approval for the individual investigations are outlined within the appropriate chapters. A clear audit trail was maintained as outlined by Hush and Herbert (2009), and where anomalies occurred, these were indicated.

In research, ethical considerations form part of the bedrock on which certain judgements are made and issues of beneficence are often weighed against maleficence. Appropriate adjustments are made to ensure the wellbeing of everyone involved. In recognition of the nature of the research, wherever there was any risk of discomfort, regular reassurance was offered with the creation of an

enabling environment in which the students felt they could freely express themselves especially when their beliefs and opinions were in opposition to those of their peers and mine. The submission of individual personal accounts completed within the investigations (see Chapter six) gave participants opportunity to be critical. Areas identified within the study which were considered to have potential for harm were mainly in the emotional and psychological effects of the teaching, discussion and questioning of certain topics with the participants. I was also aware of my own sensitivities and ethical stance which I brought to the study and as an experienced lecturer; teaching skills developed over many years were adapted and adopted as appropriate.

The ethical implications of case study and action research are probably less problematic in some areas than in certain other types of research but they bring with them their own challenges, for example in making overt the inter-personal relationships the researcher has with the subjects. My relationship with the students has been on a professional level where I have acted as lecturer, personal tutor, dissertation tutor and advisor. Social interactions have been limited to professional activities and from a personal perspective, these have been positive.

My approach in managing my ethical responsibilities throughout this study was guided by professional codes of practice including those of the professional body and national regulatory body with whom I am registered, namely the CSP and the HPC.

4.4 Learning and teaching in the BSc (Hons) Physiotherapy programme

An overview of the programme may be found in the Programme Handbook and the Three Year Plan offered in Appendix 4. Lecturing staff were also qualified physiotherapists. External speakers and lecturers came from further afield and gave input at different stages within the programme. The study was focused on the learning and teaching of cultural competence within the curriculum, and whilst it is recognised that learning and teaching about a topic does not occur in isolation, for the sake of these investigations the focus remained in areas within the curriculum where the subject could be readily identified.

Capturing the process of learning and teaching of cultural competence within the curriculum was an important part of the data collection. It centred on two modules, the Illness, Behaviour and Research module in year one and the Clinical Studies module in year two. There was no presumption that the learning and teaching of the topic were only contained within these modules. However, since the curriculum was centred on the achievement of learning outcomes, modules which appeared to have direct relevance to the investigation were used as the basis for selection. The extent to which the learning and teaching of cultural competence might have pervaded the curriculum is followed up in the discussions at the end of this chapter.

Teaching in the illness behaviour and research module

The IBR module, a 30 credit module taught over 12 weeks in the first term is in three strands – Research Methods, Behavioural Science and Clinical Studies. I made a contribution to the module in the two aspects described below and it can be seen from Figure 1 that only a minor part of identified topics related directly to the subject of 'culture'. The module in general, offered students experience in learning and teaching about illness and associated behaviours together with an introduction to research.

Figure 1 Plan of Illness Behaviour and Research Module – Adapted from BSc (Hons) Physiotherapy Handbook

	Week	Research Method	Behavioural Science	Clinical Studies	
Semester 1	1 5 7 9 11 Reading	Library & computing Approaches to research Measurement Data collection	Introduction to Learning Social Psychology Communication 1	Introduction to disease Rheumatology Trauma 1	Correlative Seminars
	13	Assessment Week			
Semester 2	1 4 5 7 10 12	Descriptive statistics Reliability, validity and control Inferential testing Research assignment	Personality motivation Illness, disability, coping Communication 2 Culture	Trauma 2 Medical respiratory Assessment of patients	

I was also involved in the teaching of the research strand of this module. Opportunity to introduce students to the use of questionnaires was timely since not only could they learn about questionnaires as a research tool and how it might be used in learning and teaching but through it, I could also gain their views on the topic of cultural sensitivity. In addition I considered that it could provide an efficient way to expose students to experiential research and as a means of introducing and exploring a sensitive topic.

CHAPTER 5 CASE STUDY – YEAR ONE

5.1 The questionnaire

Questionnaire as a method of data gathering

Questionnaires are often used in research to elicit various forms and types of information from respondents and to give a general profile. In this study it was used as a data collection tool to elicit facts, opinion, knowledge and beliefs (see Appendix 5). The strengths of questionnaires as a research tool are commonly acknowledged (Oppenheim, 1992; Moule and Goodman, 2009). They are often used in a variety of research contexts, such as surveys, descriptive studies and randomised controlled trials. As was the case in this study, they are often standardised with the same questions presented to the respondent as self-completion tools. Alternatively, they can be completed by the researcher.

Challenges lie in formulating a tool which is reliable and valid i.e. one which has ability to measure what it is expected to measure and demonstrates consistency of measurement in its repeatability. Validity may be defined on a number of aspects based on and including face, construct, criterion and content parameters which may be established by the use of an expert panel. The questionnaire used in this study (see Appendix 5) was developed by Clifford et al (1999) where I was instrumental in its development. Further investigations will be required to verify its reliability and validity. In relation to its face validity, consideration was given to the

resistance which could have arisen in completing it if the students could not understand or make sense of it or could not relate to it (Payton, 1994). There was no need or desire to disguise its purpose. All types of validity relate to construct validity and the questionnaire was adopted with this in mind. It allows individuals to address and answer the question regarding what the results of a test actually mean. It is particularly important in measuring concepts which are difficult to measure directly as was the situation in this case to gain a perspective on the students' perception of cultural competence. Payton (1994) identifies that operational definitions are particularly critical where there may be difficulties in measuring the construct directly, hence definitions given at the beginning of the questionnaire were considered appropriate.

The advantages and disadvantages of gathering data by using questionnaires have been documented by many authorities on the topic, for example Oppenheim (1992). They offer the researcher a means of gathering significant quantities of information over a relatively short period and this factor was utilised. However, in this regard, they often offer the respondent little opportunity to give in-depth accounts or analyses in their responses, and therefore the use of other methods of data gathering were incorporated into the study.

Reactivity in the design and delivery of the questionnaire were carefully considered in evaluation of the responses i.e. the risk that some of the answers elicited would be prompted by the way the questionnaire was designed or administered (Abbott and Sapsford, 1998). The extent to which the questionnaire

could be considered reliable or valid and its robustness may also have been improved by using a pilot.

Purpose and justification

The main aim of the questionnaire was to investigate the self-assessed ability of undergraduate physiotherapists to care for MEGs. It was presumed that the responses obtained at its first issue, Time 1 (QT1) would be based on the students' knowledge and experiences gained prior to the formal introduction of the topic within the programme and before clinical experience, and that this could then be compared with its second issue at Time 2 (QT2). The hope was that analysis of data from the two questionnaires would contribute to an understanding of the students' perceptions of cultural competence and how it changed over time.

The opportunity to gain an individual's point of view without the influence of discussion with other people in a relatively easily retrievable format was also considered to be an important advantage. The sacrifice of gathering 'rich' and in-depth data was compensated for by the wide scope of the topics that could be covered in a given time, despite the length of time taken to compose the questions initially. The intention was to triangulate the data with data from the other approaches including interviews and repertory grids and to identify the degree of consistency in the factors elicited.

Development and administration

I was involved in the teaching of the research strand of the IBR module. The opportunity arose for an introduction to the students in using questionnaires. Approval for the use of the questionnaire 'Caring for people from minority ethnic groups' was gained by Clifford et al (1999) (see Appendix 5). Its distribution took place within a normal classroom which was furnished with individual desks and chairs which accommodated the cohort comfortably. Students had gathered for a lecture where the general topic was 'approaches to research'. This fitted with the learning outcomes for the module which included one of the 'concepts of measurement and methods of data collection' (see Appendix 6). Its introduction was timely as it afforded opportunity not only for them to learn about questionnaires as a research tool and its use in learning and teaching but also as a tool to gain their views on the topics of cultural sensitivity This activity marked the start of the study. I considered QT1 provided an efficient means through which to expose the students to experiential research and as a way of introducing and exploring a sensitive topic.

Before students were invited to complete the questionnaire, I offered an outline of my research and explained that their involvement could potentially assist in the learning and teaching of the topic. I also took time to explain that completion of the questionnaire would in no way affect any formal mode of assessment or any marks awarded to them on the course. In attempting to guard against bias and to increase the objectivity of the evidence obtained both in the content and delivery, anonymity of the forms was assured. Since the lecturer-student relationship could

have affected the responses of students and how some of the questions were answered, students were further reassured of the independence of their responses and the importance of feedback in development of the curriculum. It had been identified in a previous study (Clifford et al, 1999) that physiotherapy undergraduates may be unfamiliar with some of the definitions and concepts of race and ethnicity and therefore a glossary of terms was included (see Appendix 5).

In order to assess change over time, the questionnaire was distributed again in year two of the programme, following the students' experiences in clinical placements, as QT2. This took place at the end of year two (see Table 1). Students were asked by way of a letter, whether they would be willing to complete the questionnaire again (see Appendix 7). Since the students did not return to the University at the end of the second year following their clinical placements, the questionnaires were relayed by staff from the University who were visiting students as part of their normal activity.

In introducing the questionnaire, limited departure was made from the normal course of learning and teaching experience of the students. It was recognised that learning and teaching of the topic could have occurred elsewhere within the programme but since these had not been made explicit in the documented curriculum any reference to the topic would have been down to the approach of individual lecturers. Identifying these episodes was difficult. Analysis of the results

from QT1 was used to inform learning and teaching of cultural sensitivity in the Clinical Studies.

Cultural sensitivity was the term adopted at this stage of the study. It had been used in the previous study (Clifford et al, 1999) which had triggered this investigation, and was a term with which students were familiar. This planned 'action' within the initially planned action research strategy remained an important survey tool when the study developed as a mixed methods case study. A reflective commentary is offered at the end of the chapter which takes this into account and some of the unplanned classroom activity which took place.

Within the Behavioural Science strand of the IBR module, and in relation to the topic of 'Culture', the stated outcome was student ability to 'develop insight into multicultural issues related to health care'. The knowledge content associated with this was identified as 'stereotyping, prejudice, questioning and listening skills – implications of a multi-cultural society'. One hour was allocated for the teaching of the topic. I was also the organiser of this session and it included offering students time for discussion in small groups to explore their understanding of common definitions of topics such as race, ethnicity and stereotyping and to examine their own health and cultural beliefs between themselves. It gave them scope to continue discussions which had arisen out of filling out the questionnaire. The role assumed by me as the lecturer was as group facilitator, as a guide to the discussions and to share and convey common understandings and standard

definitions of terms. The level of learning was considered to be the equivalent to Level C (QAA, 2010)

Data preparation and analysis

The questionnaire was divided into two sections and used open, closed, factual and attitudinal questions. Section one invited students to submit biographical data which included categorisation of their profession, year of study, age and gender. The second, main section included questions related to ethnic groups, views on ethnicity, professional activity, NHS and minority groups, education, caring ability, problems encountered, specific lectures, student preparation, ethnic disease prevalence, resources and general comments. It was issued and completed within 30 minutes by 45 students. As part of the teaching session, this was followed by discussion on the concepts of self-identity, culture, prejudice, discrimination, race and ethnicity, triggered by some of the questions.

Data were analysed and displayed through SPSS (Statistical Package for the Social Sciences). Results are reported at the end of this section for QT1. A comparison of these with the results from QT2 in year two of the case study when the questionnaire was administered sixteen months later follows in Chapter six. Interpretation of findings from QT1 and QT2 follow later in triangulation and evaluation of the study.

Findings: QT1

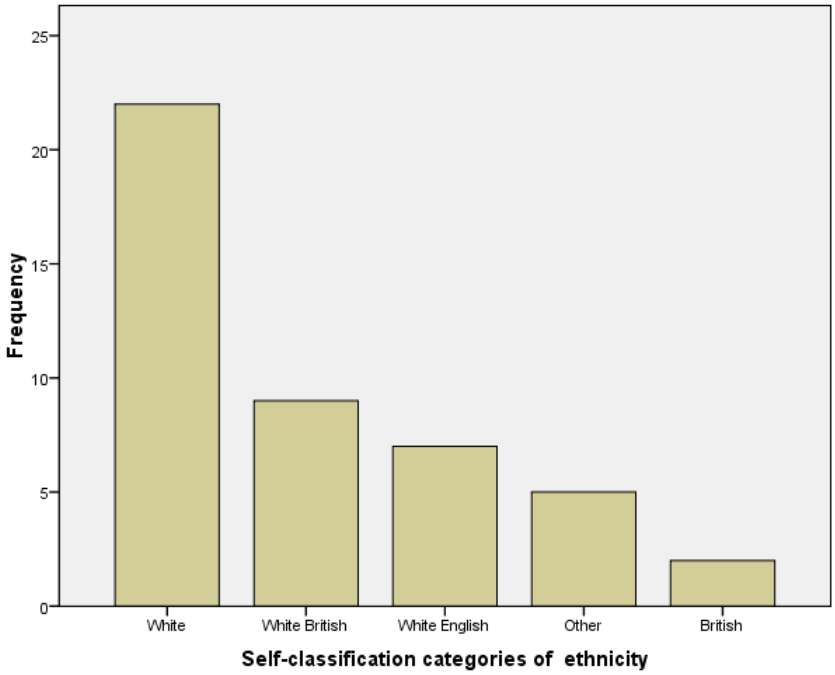
Biographical information (Q1-1.4)

All 45 respondents answered the first four questions and identified themselves as first year physiotherapy undergraduates aged 18-25 with the exception of one undergraduate who was aged 25-35 years. There were four males.

Ethnicity (Q2)

Students classified their ethnicity in one of two ways, by self-categorisation in response to an open question, and by responding to a closed question on the same issue. The response rate was 100% for both questions. Responses to the open question showed that the majority of students chose colour as the main feature of their ethnicity and country of birth as the next most common feature i.e. White/British and White/English (see Table 4). In the 'other' category four out of the five students identified religion as a feature.

Table 4 Students' self-classification of ethnicity



In the closed question, Q2.2, the students were requested to tick one of the ethnic categories listed. All of the responses in this section were given as 'White'. However, nearly half of the group remarked that this form of forced categorisation was inadequate as indicated in their responses to the question which followed (Q2.3). This question asked: *In the context of your own definition in 2.1 do you have any views on the above [forced] categorisation – if yes, please comment below. If no, go to the next question*. There were 20 responses to this question. Ten of the responses highlighted the limited nature and breadth of the 'White' band, eight highlighted that 'White' was not one group and seven of the respondents questioned 'Irish' as a separate category. Examples of these comments are offered in Box 4. Eight out of the 20 responses commented on overlap between 'White' and 'Irish'. Four comments were centred on the nature of ethnicity, Jews and other world religions.

Box 4 Comments from Students on the Closed Categorisation of Ethnicity

'Very broad a wide range of people fit within the band' (A8)
'Why do 'blacks' get lots of categories and 'whites' only one and why is a religion incorporated – can't Jews be any skin colour?(A10)
'Why does Irish have a separate category? Shouldn't it be included under 'white' category?'(A18)
'Irish is a country thing, the others are all races.' (A19)
'Why is Irish a separate group – it's a country.' (A20)
'Why is Jewish defined as a category? Jewish would indicate religion and others indicate geographical region or colour.' (A21)
'I could be Irish and White, Irish and Jewish, Jewish and White, so not conform to just 1 group.' (A31)
'The above groupings include groupings from religion, geographical location and physical appearance.' (A32)

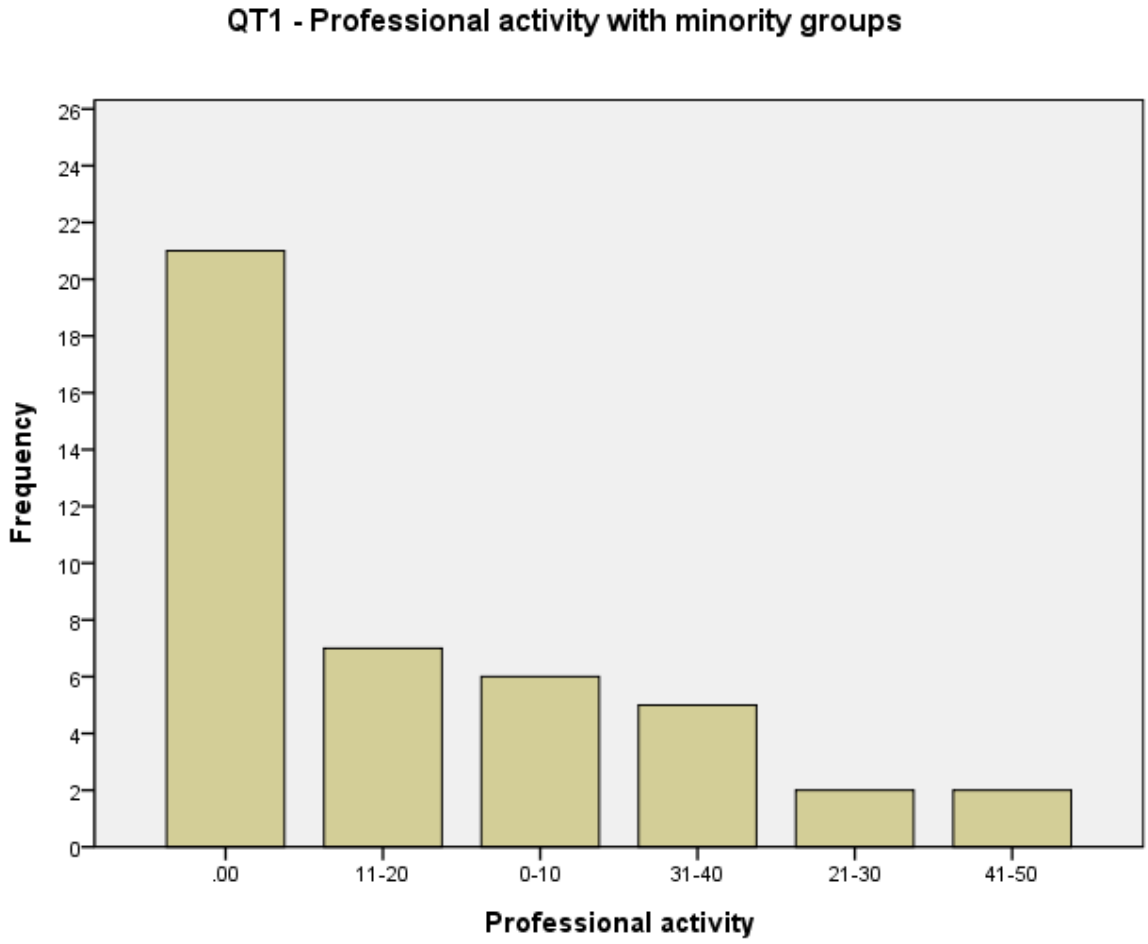
Note: The number following each comment refers to the student code number.

In summary, these responses identified some dissatisfaction with the standard system for classifying ethnicity. Subjects objected to the lack of specificity in the 'White' category and the apparent mix of nationality with religion and with colour.

Professional activity with minority groups (Q2.4)

Students were asked to identify the amount of time spent with minority groups in a professional capacity. Twenty-seven students stated that their professional activity with these groups was 10% or less (see Figure 2). This was consistent with the type of activity that they were experiencing on the course at that time. They had not yet experienced clinical work, and any interaction gained with MEGs would have occurred through their academic activities and work experience gained prior to beginning the course. The remaining group of students identified higher levels of interaction but this amounted to 30% or less.

Figure 2 QT1 Professional activity with minority groups



Students' ability in meeting the needs of patients from minority groups (Q2.5)

Students rated their ability to meet the needs of patients from MEGs compared with that of the majority white population on a 10 cm visual analogue scale. The mean mark for the MEG and majority group was 52.5 cm and 76.0 cm respectively. Using a t-test, the difference in measurement between the two marks was statistically significant at the 0.001 level. The students identified that they felt less able to meet the needs of MEGs than the majority white population.

Common problems faced by students when caring for people from MEGs (Q2.6)

This open question invited students to identify problems they might face when caring for patients from MEGs. Thirty-seven provided responses. These were grouped into three main areas: language (n=17); lack of experience in caring for MEGs (n=10); and a mix of factors which included religion and lack of knowledge. Some students identified more than one problem, hence the total number of comments from each area exceeded the number of respondents. An illustrative comment from each theme is presented below:

> *Language*
> *If I am unsure what they are saying because I did not speak the language that would be a problem, if I am not fully aware of any special requirements which need to be taken when dealing with people of certain religions e.g. dress.*
>
> *Trying to communicate verbally can be frustrating without somebody who can translate, if there is an extreme lack of vocabulary on both sides.*
>
> *Lack of knowledge, language*
> *Not fully understanding issues related to religion i.e. dress code, language barriers.*

The origin of these problems was not always explained.

Awareness of issues attributable to ethnic origin where colleagues have had particular problems (Q2.7)

Ten of the 45 students indicated that they were aware of issues attributable to ethnic origin where colleagues have had particular problems. Fasting and vigorous activity were identified by five and four of those students respectively, while two

mentioned ‘constraints placed on women’. Individual students mentioned undressing, translating, language and religion.

Assisting minority groups to get the best from the National Health Service (Q2.8)

Students were asked to identify the factors that they thought would assist MEGs to get the best from the Health Service. Of the 41 responses, 13 students identified knowledge and education, 11 noted understanding, eight referred to respect while five mentioned increasing the awareness of professionals. Equal treatment, no racism or discrimination and interpreters were some of the other factors identified by individuals.

Barriers for patients from different minority backgrounds in receiving the best from the NHS (Q2.9)

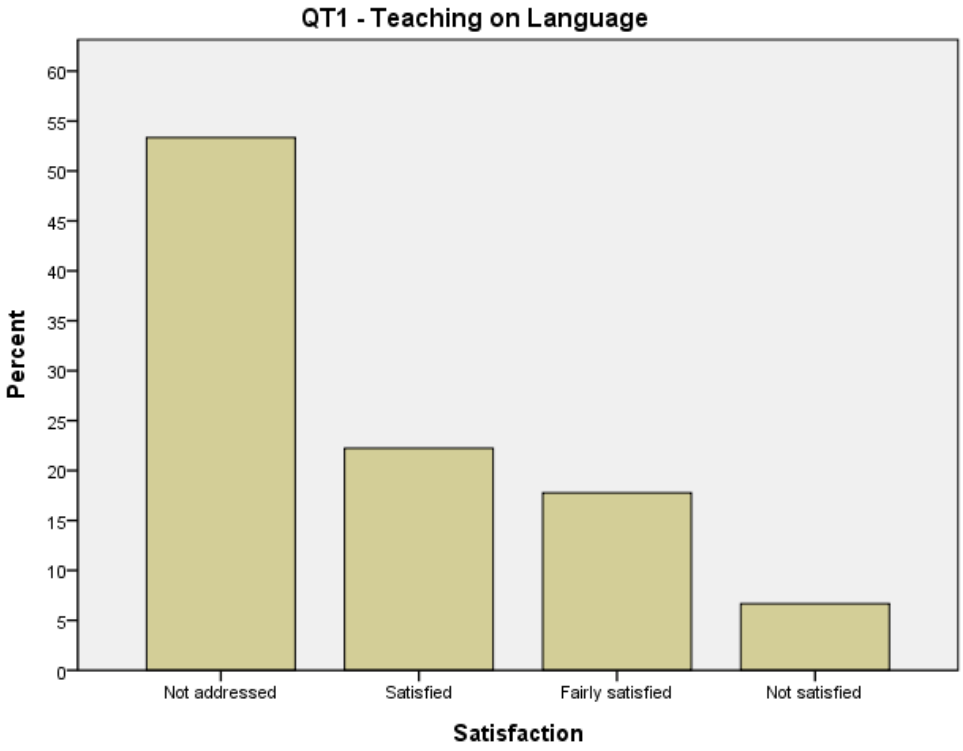
Students were then asked to identify the barriers that might prevent MEGs receiving the best from the NHS. There was a 100% response to this question. Students identified language (n=28), beliefs and cultural issues (n=24), lack of or poor understanding and communication (n=14), lack of knowledge (n=7), lack of respect (n=5) and racism (n=3). Other factors highlighted included discrimination, stereotyping, unequal treatment, prejudice and being dismissive. Some students identified more than one issue.

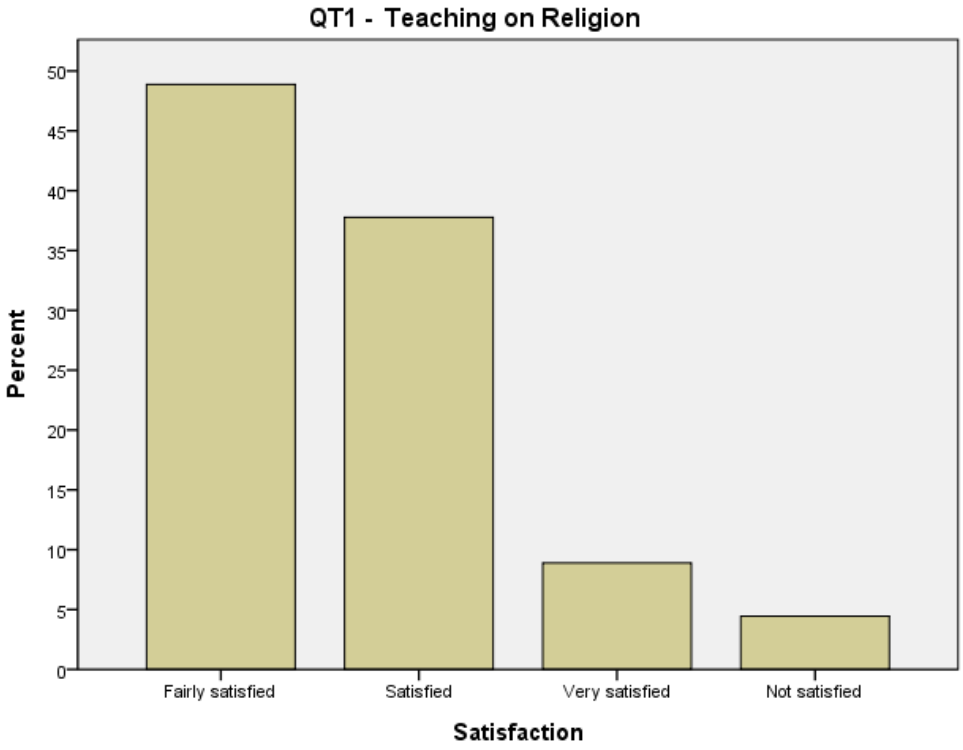
The next set of questions sought views from the students on how well they thought university education prepared them for working with MEGs.

Satisfaction with the education systems within the university setting (Q2.10A)

The following charts show students' level of satisfaction with the education systems within the University setting in helping them to meet the needs of MEGs. There was a variation in the responses in the three areas considered – language, religion and culture.

Figure 3 Satisfaction with teaching on language, religion and culture within the university (Q10)





Twenty-four (53%) students stated that in relation to MEGs, language was not addressed in the academic setting but the majority felt satisfied or fairly satisfied with their education in religion and culture.

Satisfaction with the education systems within the clinical setting (Q2.10B)

A parallel question about the level of satisfaction with the educational systems within the clinical setting was presented in the questionnaire in an attempt to identify where the students felt they were gaining the greatest contributions in the development of their cultural sensitivity. Four students answered this question even though they had not completed any clinical work. This may have been due to

misinterpretation of the question or students had related the question to their previous work experience before entering the course. The question was a relic from the pilot questionnaire and was not applicable at this time.

Number of lectures attended (Q2.11)

This question aimed to identify the number of lectures students had attended that were concerned with caring for MEGs. The majority of students (n=42) identified that they had attended between one and five lectures. This was consistent with the number of lectures which had been offered elsewhere within the curriculum on religious issues and culture in a previous module. Three students identified that they had not attended any lectures on the topic. The students identified the topics or related topics as different religions (n=29) and cultural studies (n=19), with others stating clinical studies (n=8) and behavioural science (n=4) and some students identifying more than one of these.

Usefulness of lectures (Q2.11)

The students were asked to assess the usefulness of lectures on a three point scale (very useful, useful, not at all useful). The majority found the lectures offered to be useful (n=36) whilst four thought they were very useful and two, not at all useful. Eighteen comments were made about these lectures. Six individuals said it gave them further insight, three felt that they were not sufficiently related to practice while three commented that there was a lot of information on religions. The remaining six made individual and different comments.

Training programmes to prepare students (Q2.12)

All but five of the students offered suggestions for training programmes that could help students prepare to meet the health care need of MEGs. The main items suggested for inclusion were for more specific information and knowledge on MEGs (n=16), speaking to individuals from other cultures and inviting outside speakers to talk with them (n=14). Three students requested case studies and real problems, and four students made no response.

Level of awareness of cultural groups in Birmingham (Q2.13)

The students' self-assessed levels of awareness of the different cultural practices in Birmingham were low and varied. Students were asked to indicate their level of awareness on a visual analogue where 0 was no awareness and 10 was complete awareness. Their mean level of awareness was highest for the Irish at approximately 5.3, for Jews 4.2, Indian 3.7 and the lowest was for Caribbean at 2.5 and Bangladeshi at 2.0.

Awareness of disease prevalence/incidence/mortality between different ethnic groups (Q2.14)

This question was designed to find out how much students knew about the prevalence, incidence and mortality rates of different diseases as they affected MEGs. Their response fell into three categories, 'yes', 'no awareness' and 'not sure'. The students had limited awareness of differences between the prevalence, incidence and mortality rates between different MEGs and were generally less sure of factors leading to mortality. There were twenty respondents and of those,

nine students identified differences in the incidence of sickle cell disease occurring in different MEGs, and six students thought lifestyle, social and religious factors may be other contributory factors.

Awareness of the availability of specific educational resources (Q2.15)

All the respondents indicated that they knew of no specific educational resources to help staff in clinical areas with issues related to cultural practices.

General comments (Q2.16)

In the final section of the questionnaire, the students were invited to make general comments. Six students contributed: three referred to the inclusion of 'Irish' in the ethnicity categorisation. Two of the other comments referred to the applicability of some of the questions. The other was a general statement about treating ethnic groups equally.

QT1 was administered in order to gain baseline data on this cohort of undergraduates. The same questionnaire was administered again as questionnaire QT2 sixteen months later after all the students had completed three practice placements, each of four weeks' duration, and gained exposure to teaching sessions within the Clinical Studies module where cultural sensitivity had been one of the main taught elements. A comparison of responses to the two questionnaires is given in Chapter six.

5.2 The group interview

Purpose and justification

The group interview was conducted four months after the issue of QT1 (see Table 1) during the last week of term in semester 2 following the students return from a four week clinical placement in the Clinical 1 module. In the interim, they had also continued to study two other modules. It was thought that the contribution and evaluation of this form of enquiry at this point, i.e. following a first clinical placement and at the end of the first year of the programme, might offer further understanding of students' experiences of cultural competence within the curriculum, and that it could also inform future learning and teaching of the topic, especially cultural sensitivity in the forthcoming Clinical Studies module in year two. Feedback from the classroom discussions in the Illness, Behaviour and Research module and findings from QT1 were further important reasons for choosing to do so. The group interview allowed the participants to give lengthier and perhaps, more thoughtful responses to some of the questions which were initially touched upon in QT1. The intention was also to gain further insight into their attitudes, beliefs and concerns about cultural competence. An interview schedule of pre-planned questions was used and a number of other questions were also elicited during the process (see Table 5).

Interviews as a method of data gathering

Investigations using an interview-guided approach are probably the most widely used format for qualitative interviewing (Sewell, 2008) because it allows some

degree of informality to be retained. The use of the informal interview allowed for collection of data, its transcription, secondary analysis, re-use of the data and also correction of error in memory and 'intuitive gloss' which could be put on the responses of individuals (Bryman, 2004). The adoption of this approach was important because of the potentially sensitive nature of the topic under investigation. It was envisaged that a small group might facilitate better social exchange of information than individual semi-structured interviews where individuals could have felt more inhibited. Although a group format was adopted, and the activity had some of the characteristics of a focus group, it was perhaps unlike a true focus group because the extent of the students' experience was unknown. Also, I considered that reliance on the interaction if left solely to the group as is normally the case in focus groups, could have been problematic because of this unknown factor regarding their experience. It is also suggested that focus groups are best conducted using relative strangers (Cohen and Manion, 2011). A number of these students could have been friends.

The art and craft of interviewing is known to be challenging (Kvale and Brinkman, 2008) and therefore, consideration was given to how the data obtained might contribute to the research from a theoretical and epistemological perspective. Further discussion on this is given in triangulation of the data later on in the thesis. Since interviews offer discourses where the outcome is produced both by the interviewer and the subjects (Kvale and Brinkman, 2008), evaluation of this had to be borne in mind. The question of whether the interviewing would capture the reality of the students' lived experiences or whether they would offer a diluted

version of their experiences was not known but the approach made it possible for me as the researcher to become absorbed into freely shared experiences of the students in a situation of openness. Alternative formats for interviews were also considered such as formal, standardised, conversational or open-ended (Patton, 2002), but for the reasons outlined above, semi-structuring the interview was the approach of choice.

Development (question schedule) and conduct

Although interviews occasionally took place within the normal curriculum, given that the material was to be a potential part of the research data, I considered it necessary and appropriate to gain formal consent from the participants (see Appendix 8).

The interview questions were centred on issues relating to cultural sensitivity and cultural competence, including the individual's ability to care for minority groups (see Table 5). It was by coincidence that after speaking to a fellow lecturer who was debriefing the students as a follow up from their clinical experience that an ideal time slot was identified within the planned session. The session had already been structured by the lecturer and one of the session outcomes was that students should analyse their experiential learning and to deliver a grouped SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis of the placement which they had undertaken. Therefore, we discussed and agreed that an interview would be an appropriate and useful way of capturing some this information; this enabled the interview to be embedded within the planned session.

At the start of the session, I explained my attendance with my colleague to the assembled group of students and the link between the planned lecture and the proposed interview. I had considered that in order to get more in-depth and meaningful responses from the interview, it was preferable that I included only those students who could identify that they had worked with diverse communities. I was unsure about the willingness of students to volunteer to be interviewed; therefore, I asked the students to indicate by a show of hands how many had worked with diverse groups of people whilst on placement. Approximately one third of the 48 students present indicated that they had. They were then asked how many would be willing to participate in a group interview in order to discuss these encounters and their cultural competence. It was apparent from the second show of hands that there would be more volunteers than could be managed in a group interview; therefore, nine individuals were chosen. Although this was one more than planned, it was assumed that there would be withdrawals, especially when they knew the session would be recorded. However, there were no drop-outs and the nine students participated. This purposive sampling meant that this group of nine volunteers formed the interview group.

The interview took place in a classroom where eight tables, each wide enough to seat two students were put together to form a square around a central table on which a microphone was placed. I explained the aim of the interview and requested that they sign a formal consent form (see Appendix 8). An allocated time of 50 minutes had been given by my colleague in which to carry out both the

group interview and the summary SWOT analysis. I, as the researcher/interviewer, sat at a table amongst the students. The interview was taped using a Sony Portable Minidisc Recorder MZ-R55 and a Bell and Howell 3158X audio tape recorder as a backup measure. It began with a brief explanation of the type of questions which were to be asked and then the first question was posed (see questions in Table 5).

Table 5 Interview questions

Cultural Competence
1. What skills do you think a physiotherapist requires to be culturally competent?
2. Do you think you have these skills?
3. How much interaction did you have with black and minority ethnic groups before the start of this undergraduate course?
4. Have you encountered any problems in treating black and minority ethnic patients?
5. What concerns do you have, if any, in treating people from different ethnic minority groups?
6. Are you aware of any formal mechanisms such as handbooks, videos etc. which might help you to work in a culturally diverse environment?

All nine students participated well. The interview lasted 40 minutes and was formally concluded but the recorders were left running. Bryman (2004) identified that some individuals ‘open-up’ near to the end of an interview and relevant information can often be obtained during this part of the process. The students were then directed to complete a grouped SWOT analysis of their first clinical

placements as requested. The module leader came into the room to make a brief enquiry about the outcomes of the interview group in relation to the achievement of the learning outcomes for the module.

The whole student group was re-assembled and a short feedback session by the interviewees was given to the year group followed by a brief summary by me regarding the relevance of the interview questions to clinical practice. Interestingly, in the group's feedback to their year group, one of the comments made by the students was that they had noticed that there was a lack of interaction with ethnic minority students in their undergraduate course and this drew additional responses from other students. This was not one of pre-planned items for discussion but it was clearly a factor of some importance to them.

The field notes made following the session identified that 'a follow-up interview session was curtailed by the demands of the module, students were very communicative throughout and unfortunately it had not been possible to have an additional member of staff in attendance throughout'.

Data preparation and analysis

The data were transcribed from the minidisk recorder as a Word document with the help of an assistant, external to the programme and the School. This initial transcription was completed soon after the interview so that with the passage of time the loss of integrity of the data was minimised. A second and more rigorous process of deciphering the content and correcting errors in the first transcript was

conducted at a later date. The process of thematic analysis began with this second transcription. It was followed by coding and reduction analysis of the data. Whilst it is difficult for the transcript to translate the mood which prevailed in the room at the time of the interview, the tape recordings offer some evidence that the students engaged in an open and enthusiastic manner (see Appendix 9).

Coding

Two coders, including myself, managed the coding of the data and adopted approaches described by Strauss and Corbin (1990). Major themes of the interview were grouped into a format using terminology adopted by the participants, but occasionally the use of labels derived from the data were employed in order to group aspects of the same theme (see Figure 4). For example, the students often used terms which were strongly related to 'feeling incompetent'; therefore, this term was chosen as the main descriptor. On the other hand, the theme that 'MEGs behaved differently' was derived from a variety of views which were expressed around this aspect, for example differences in family expectations and attitudes towards undressing. Further and more in-depth analysis of the transcript and the themes was undertaken to identify how and to what extent the participants had answered the interview questions. Thereafter, the process of evaluation continued until it was felt that a point of saturation of the data had been reached and that there were no 'new' data that could be derived. This process of working back and forth between the data using the researcher's own perspective and understanding in order to make sense of the evidence is well

recognised by qualitative researchers to be a valid approach in the search for theory.

Different ways of analysing interview data are recognised, such as meaning condensation, meaning categorisation, narrative structuring, meaning interpretation and generating meaning through ad hoc methods (Kvale and Brinkman, 2008). The data and transcript were revisited on a number of occasions with these considerations in mind in the writing up of this study, in a quest to seek further meanings and interpretations.

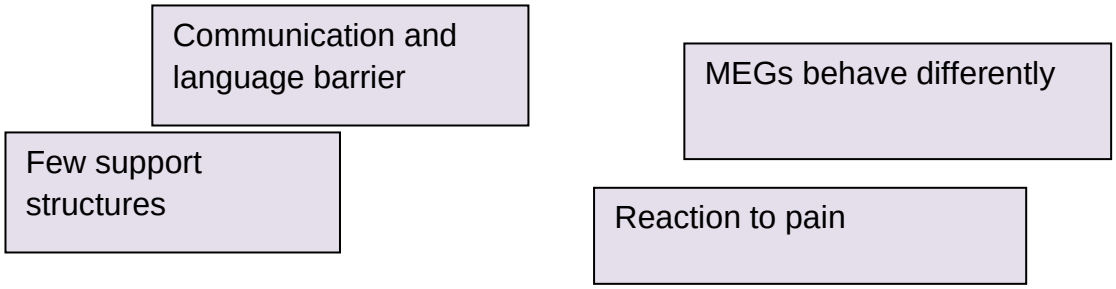
The summary of derived themes and actual responses of the students were cross-checked with those of an independent assessor in order to arrive at a consensus before final conclusions were drawn.

Findings

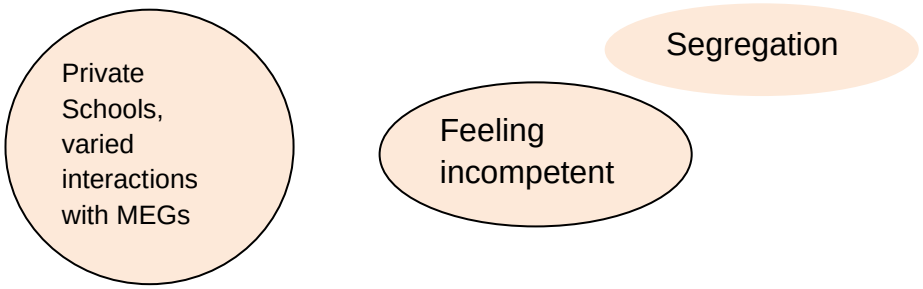
In relation to minority groups, the main themes arising out of the interview were identified as: 1. communication and language barrier, 2. pain behaviour, 3. student strengths in communication and 4. lack of support structures. The sub-themes were identified as: private schooling, varied interactions with minority groups, feelings of incompetence and segregation.

Figure 4 Coding themes of interview

Main Themes



Secondary themes



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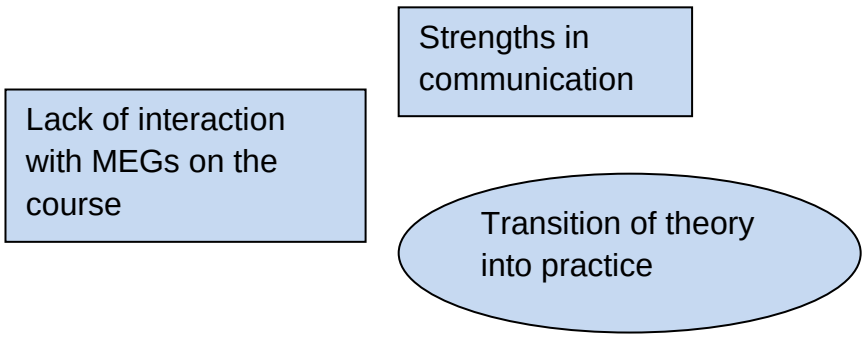
<u>Post interview</u> (tape left running after the formal interview)



Responses to each question asked in the interview are reported in Table 6. This is then followed by the additional findings which emerged from evaluating the data.

Table 6 Summary of responses to interview questions

Question number	Question	Responses
1	What skills do you think a physiotherapist requires to be culturally competent?	Understanding culture, language barrier and difficulty knowing what to do
2	Do you think you have these skills?	Feel incompetent, need experience, communication difficulties and frustration
3	How much interaction did you have with black and minority ethnic groups before the start of this undergraduate course?	Mainly white schools, private schooling and limited mixing with MEGs
4	Have you encountered any problems in treating black and minority ethnic patients?	Obvious differences, specific cultural issues and different family expectations
5	What concerns do you have, if any, in treating people from different ethnic groups?	Undressing, low pain threshold, expressions of grief and the need to treat people as individuals
6	Are you aware of any formal mechanisms such as handbooks, videos etc. which might help you to work in a culturally diverse environment?	None, leaflet

The depth, and breadth of responses were very varied but the respondents spoke with strength of feeling on the language barrier, different cultural behaviours, in particular responses to pain by different minority groups, their strengths in communication and the little or no support structures available to help them to work with different minority groups.

Quotes are presented below to illustrate the four main themes – 1. communication and language barrier, 2. behaviour, pain behaviour and culture, 3. student strength in communication and 4. lack of support mechanisms. They express some of the dilemmas and anxieties faced by the students in their attempts to engage with minority groups.

Theme: Communication and language barrier

Within the theme of communication, students spoke about varied scenarios and difficulties they had faced in establishing meaningful communication with service users and their families. They spoke of experiencing a range of feelings including frustration, incompetence and helplessness while trying to deliver the best treatment they could. The examples below were indicative of some of the discussions.

> *Student: I always used to think, you know before I went out, that language barriers weren't going to be that much of a problem…but I just felt incompetent*

> *Student: I was left with a gentlemen who I don't know what language he spoke, but he did have limited English, but I was left to try and teach him better posture, and I just felt like I was banging my head against a brick wall, he just wasn't understanding what I was saying, and even when I tried to show him, he just didn't seem interested in what I was trying to tell him.*

> *Student: She was looking at me, held my hand and was just speaking and I didn't have a clue what she was saying, and it's not like I wasn't trying to get anything across to her....*

Theme: Behaviour, pain behaviour and culture

Students appeared to link certain kinds of behaviours to minority groups. Therefore, in an attempt to tease out their views, occasionally I used questions as probes in order to gain a more in-depth response to other questions. For example in relation to pain behaviour:

Researcher question:

'Would you say that was peculiar to him as a minority ethnic person, or just any individual at [x] who might be seeking compensation?'

> *Student: It was more noticeable with him…if he was still complaining, they were gonna send him to the works doctor and then he'd say if they were fit or unfit, and I think they were doing that this week…cause it was getting to the stage where it was wasting their time when they could see proper patients that did have genuine complaints…*
>
> *Student: They had to like obviously wear special splints and everything on their legs and they [meaning family] didn't agree with them wearing them, so the school couldn't allow them to take them home…*

Researcher question: 'You put this down to a minority group issue or not?'

> *Student: Erm yeah I think it was, the physio I was working with seemed to think it was…*

Specific cultural issues were the pervading theme.

> *Student: You know she was gonna literally go home four days after her operation and go straight back into .... and I think that was definitely cultural.*
>
> *Student: gender preference of staff by patient, non-English speaking, reliance on partner as translator – question of reliability of this, undressing.*

Student: had to knock on door so patient could put on scarf, when patient was with sisters fine but when doctor appeared put scarf on, inhibitions like that in dressing.

Student: I don't think you can make them undress.

In relation to pain behaviours, it was interesting to note the verbal expressions of the student in their discussions of minority groups and pain behaviours and tolerance. The perspective from some of the students was that there were clear differences in the pain behaviours of minority groups. The responses were not elicited through a direct question but it was a theme which was prevalent in some of the responses. Below are examples of the relationship of this response to the question of 'What concerns do you have, if any, in treating people from different ethnic groups?'

Student: clinical educator …ethnic minorities in general tend to have lower pain thresholds than Caucasians, it's definitely a culture thing, cause all Asian people that I saw were, made so much more of a big deal about it, and if it hurt and they weren't doing anything and that was it.

Student: It wasn't just Asian people that I came across, like black, err there was a black gentleman that was terrible, he just wouldn't do anything.

Student: and I did notice that the minorities seem to say that their pain was there whatever they did…that nothing would make it go away at all

The view of one student was that perhaps the Chinese were more stoical. This was in contrast to some of the other statements made about pain tolerance and minority groups in general.

Student: Chinese lady, you could tell she was in a hell of a lot of pain, cause her eyes were watering but she was determined not to show it, especially when her husband was there.

It was also evident that one student held an opposing view.

Student: I didn't see any of that, I have to say all the ethnic minorities I saw, there was no difference at all.

Theme: Student strength in communication

The majority of students clearly felt that their ability to communicate was one of their strengths but that this was a challenge when working with minority groups.

Student: Ironically I've put that one of my strengths was communication because in general urm I get on very well with my patients.

Student: and my strengths erm communication and doing subjective assessments.

Student: erm yeah mine's basically the same, erm…communication, assessment yeah interesting, strengths.

Theme: Lack of support mechanisms

The students identified a lack of support structures and felt that if there had been appropriate resources to hand then they might have felt more competent in treating patients from minority groups. This conclusion was derived from statements such as those given below:

Researcher question: 'So, was there any help available?'

Student: Relatives…normally her husband came with her, but he couldn't park the car so in this one instance she was completely on her own. We had a translator for one session, but it was not particularly helpful…

Researcher question: 'Have you heard about an advocate scheme?'

Student: I think that would be a good idea…

Researcher question: ‘Are you aware of any formal mechanisms such as handbooks, videos etc. which might help you to work in a culturally diverse environment?’

> *Students: Nothing…..*
>
> *‘yeh yeh’ (in chorus).*
>
> *Student: And there’s that advocate thing that you mentioned that… I think would be very useful for the situation I saw… I haven’t seen any of it in practice, you hear about leaflets, but they just don’t seem to be available, cause I haven’t seen anything.*
>
> *‘Yeh yeh…’ (in chorus).*

Sub-themes

The sub themes of segregation at school or college, private schooling, varied interactions with minority groups and feelings of incompetence, were all issues which the students shared voluntarily and which they felt had impacted on their ability to care for minority groups. The background of the students appears to be one of the factors which they offered as having a significant impact on their interactions with minority groups. The majority of the group identified that during their schooling they had little contact with minority groups, and that even when they had contact there had been elements of self-selected segregation in the social areas within their schools. The students offered very little explanation for this but suggested that individuals probably preferred to be with their ‘own kind’. One student was surprised to hear derogatory comments levelled at minority groups by fellow students on campus, when she had never experienced that level of disharmony from where she came and that her past experiences had been generally amicable.

It was not possible to gain final verification of the conclusions drawn from this interview because follow–up contact with the interview group was lost when they graduated. The reader is invited to listen to the taped interview and/or read the transcript to assess for themselves the interactions of the respondents. Responses to the interview questions are highlighted in the transcript in Appendix 9. Additional data collected post interview while the tape recorder was left running spoke of better ways of being taught, acquiring the basics before clinical work, strengths in communication and weakness in transition between theory and practice.

Discussion

The primary aim of this interview was to investigate aspects of the students' view of their cultural competence, issues of concern for them in treating different minority groups and their awareness of any help available to support them working in culturally diverse environments. Students' views were centred on problems in communication between them and patients from minority groups although they considered their skills in communication to be good. The perceptions of the group were that individuals from minority groups exhibited different behaviours especially in their reaction to pain, and the issue of a distinct lack of support structures to assist them in working with MEGs was also identified.

The inability of health care practitioners to speak the same language as the patients/clients with whom they work is a recognised problem (Jaggi and Bithell, 1995) and the students were clearly expressing this as a major problem in their

day-to-day practices. The extent to which health care curricula has prepared students to tackle this issue is questionable. Neither the students nor the staff with whom they came in contact appeared to be fully prepared to deal with non-English speaking patients, although language might not always be the sole barrier. In recognition of the fact that the majority of practitioners are not and might not become multi-lingual during their professional lives, identified structures and strategies to enhance communication with individual minority groups should perhaps be in place in all health care settings. Since this study was initially conducted there have been numerous developments in the area of cross-cultural communication and the use of translators and interpreters is evident in health care policy and practice. Yet, despite this, the undergraduate health care curricula continue to struggle to find the most appropriate ways to deliver diversity education and to solve some of these issues (Dogra, 2005).

Given the students' self-assessed high levels of ability in communication skills as evidenced in the dialogue, they still identified that they needed specific skills to assist them in their communication with individuals from different minority groups. It would seem that the challenge for educators is to challenge and locate this perceived excellence in communication skills by students within the context of intercultural communication. Further research is required into health care curricula which recognises this discrepancy in professional communication and cross-cultural communication and identifies strategies aimed at overcoming them (Betancourt and Cervantes, 2009).

It was a little surprising to find that the emphasis of some the responses from the students were centred on the behaviours of individuals from minority groups, especially in their reactions to pain, given that this emphasis was not a part of the direct content in any of the questions posed. Researches surrounding the reaction of individuals to pain from individuals in identified groups are prevalent within the literature (Tan et al, 2008; Dawson and List, 2009; Narayan, 2010). The students' perception of the behaviour of minority groups to pain also appears to reflect this and indeed was perpetuated by some of the clinicians with whom students came into contact.

Interpretation of how pain is expressed by different cultures is a theme which is generally given insufficient emphasis in undergraduate health care curricula; yet, pain is one of the most common manifestations of pathology presented to health care professionals. Recently, pain management clinics have recognised the importance of studying the manifestation of pain behaviour in different groups (Narayan, 2010) and further strides are being made at postgraduate level to understand and manage some of the issues. Practising Physiotherapists probably spend the majority of their working lives assessing and managing manifestations of pain. Students understanding of expressions of emotion such as pain, sorrow, grief etc. is generally from a Eurocentric perspective within the contexts in which they work. The need to develop an alternative eye, i.e. looking beyond the perception of self and that of the other participant, is a skill which could be taught. Different cultural expressions of emotions within the workplace bring varying degrees of unfamiliarity to both the clinician and the patient. Understanding these

demanding contexts puts the onus on the clinician to put the patient at ease and requires skills of inter-cultural communication.

The multiplicity of skills which the undergraduate physiotherapy student is expected to develop through the undergraduate programme should not be underestimated. The acquisition of additional skills in multicultural interactions in an already overburdened curriculum requires careful planning. However, given that skill acquisition is multidimensional, encompassing cognitive, behavioural and psychomotor elements, it is suggested that it is possible to embed skills of cultural competence in a framework which may be already task-orientated.

The effect of an individual's social background and their ability to care for individuals from minority backgrounds is unclear. It is possible that being brought up in and exposed to multicultural environments may assist in equipping individuals to work in a multicultural health care setting. However, the argument is also forwarded that the acquisition of skills of cultural competence may also have to be taught. In a more structured approach where there are identified elements of education, there are lessons to be learnt for all undergraduate health care students irrespective of social background. It is suggested that further considerations regarding the entry behaviours of all undergraduate physiotherapy students in relation to their skills in cultural competence should be explored, and that the curriculum should be tailored to meet their needs and the needs of the service users with whom they will inevitably come into contact.

Feelings of incompetence are common phenomena in novices, and it was not unexpected that these first year students were identifying anxieties of incompetence in relation to caring for individuals from minority groups. However, the lack of support structures to enable them to tackle the issues should be a cause for concern. None of the students was able to identify resources which could have assisted them, although it could be deduced from their discussions that they placed heavy reliance on their clinical educators. Since this study was conducted, numerous resources have been introduced which address managing diverse groups, for example CultureVision (2010) a web-based resource from Silver Spring in the US. However, mechanisms to educate, assess and explore the abilities of undergraduate health care students in using them remain relatively unexplored and questions around their appropriateness in certain contexts still remain.

The nine interviewees gave a snapshot of their individual experiences as undergraduate physiotherapy students attempting to deal with cultural issues. Each student participated to a greater or lesser degree but everyone made an identifiable contribution which may be heard on the tape. Several issues arose which give insight into some of the challenges faced by them as they attempted to grapple with the skills of cultural competence. Attempts by the students to 'justify, excuse, legitimate action or behaviour' is a recognised form of accounting made by social actors to construct their world (Coffey and Atkinson, 1996). The accounts offered by the students, appeared to support, justify and to excuse certain actions. For example, on the one hand in referring to language barriers, one student stated

that ‘it was a struggle but …it’s hard to prepare yourself… whilst another stated ‘there will be a situation where perhaps you won’t understand what they are talking about and you can’t do anything about that’. The accounts offered by the students should not be perceived as being totally transparent and there was insufficient time in which to identify more closely how and on what basis their views might have been constructed.

The outcomes and key features of the interview lay not in the individual and personal accounts but in the general overture portrayed by the data. It was possible to identify that the undergraduate physiotherapy students felt ill at ease when managing certain aspects of care for individuals from minority groups. Difficulties in communication, in particular language, were a major feature and resources to assist them were relatively non-existent. The behaviours of individuals from minority groups were perceived to be specific in some ways and students surmised that the pain threshold of individuals from minority groups were a particular challenge in treatments. The extent to which they felt they could be prepared or should be prepared to treat individuals from minority groups requires further exploration.

5.3 Reflections on the first year of the study

The case study began near the start of the undergraduate programme after I had known the students for approximately five months. I began investigations without really knowing where they might lead or how they might affect my relationship with the students but I was optimistic that the outcome would be positive.

My decision to include and start with a questionnaire, in addition to the aims of the study, was also a way of getting to know the students a little better. Its use as part of learning and teaching was not unusual as students were often exposed to completing them. Perhaps more of a concern at the time was that they might adopt a lackadaisical approach in so doing. I considered its introduction to be relevant to the context i.e. within an 'approaches to research' session; however, given that the students were aware that it was part of a PhD project, I wondered whether they approached it more as a form of data collection rather than as a part of their learning of the topic.

Discussions which had centred on ethnicity with this group of novice learners was a personal challenge for me, especially in identifying and demarcating my own personal and professional boundaries as a black lecturer. I was aware that the students were at the start of their own professional development and that they were also at an early stage in the process of professional socialisation within physiotherapy. The topic of professional socialisation is taken up later in the main discussion but there was the potential to alienate students, or in contrast, and more of a concern, was that they would engage with the topic only because it was something they thought had to. I felt that there was a danger that rather than engaging actively and purposefully, they would take on the role of passenger or passive learner. Milner (2010) highlights the importance of teachers developing cultural competence to enable student learning and draws analogy between practising democracy and culturally relevant pedagogy where both are deemed to

be fundamental principles to what we believe and who we are. Milner (2010) suggests that teachers practise democracy to foster and support and enable student learning because democracy infiltrates society. Similarly, culturally relevant pedagogy involves fostering, guiding and influencing teachers' decision-making abilities. However, perhaps there the similarities end, because unlike democracy, its infiltration within the curriculum is markedly different.

The relevance of culturally relevant pedagogy to my own situation at that time included enabling students to examine the relevance of their own culture alongside those of others and to use it to gain positive outcomes as physiotherapists. I viewed this as an important development in their learning. I did not know whether students saw me as a lecturer, black lecturer, black female lecturer or black female physiotherapy lecturer, physiotherapist, one of these at different times, none of these or all of these at the same time. However, of greater importance to me was whether and how they tried to make sense of multiple identities. It was an exploration and development in learning which I hoped that as we journeyed together through course, we would be able to contemplate. I realised that the part played by me implicitly and explicitly in conducting this research and my presence away from it whilst still teaching on the programme could have effects varying from positive to negative in this and other aspects of learning and teaching in which I was involved. I was also aware that I too was on a learning curve and although colleagues were generally supportive, this was a relatively sensitive area where colleagues had also raised their own insecurity in teaching the topic. In support of my own development, I attended numerous seminars and conferences and sought

guidance from networking, the literature and suggested contacts. My background and years of experience also made me aware that there could be potential areas of interpersonal conflict, consequences on student satisfaction ratings and increased workload in developing new strategies for learning and teaching. Additional implications of the type of role model against which students might judge me and their significance gave me room for further thought.

Alongside this research, I continued my normal involvement in the day-to-day activities of learning and teaching including curricula planning, staff meetings, teaching other student groups, conducting other professional activity and in my role as carer, partner and mother of three children. My view was that these external activities could influence my planned research, especially in view of workload, but the view which I had adopted was that the research was likely to continue because it was a part of my ‘everyday activity’.

There were no overtly dissenting voices from other lecturing staff on the programme about inclusions I had made within the curriculum so far. Revisions to curricula occurred as agenda items in the curriculum development committee and there had been formal agreement to the developments for my research. Nonetheless, I had to continue to contemplate the ‘buy in’ factor from staff and other relevant stakeholders.

In hindsight, little time was spent in the analysis of the questionnaires as a research tool with students and this was because of limited time within the

timetable and discussions had been strongly influenced by its content, especially on race and ethnicity. I was aware that students may have thought that I had a personal agenda in pursuing the topic but I surmised that those thoughts would not have been too dissimilar to those given to other topics of interest pursued by other staff with their own research agenda. Nonetheless, I felt that there were some differences to be contemplated, especially because of the nature of the topic and further consideration is given to some of these factors in further reflections within the thesis.

I had to contemplate the next stage of the study. Initial analysis of the questionnaires highlighted areas from which further action in the action research cycle could have stemmed. I decided on conducting the semi-structured group interview about this time, after students had been on the course for one year. It is perhaps not very often that staff are afforded the opportunity to explore a topic of personal interest with a small group of students and a topic which they also consider to be an important part of their students' professional development. I was pleased in the honesty with which students engaged with the process including the fact that they felt able to describe unacceptable behaviours of peers on campus and to share the high levels of anxiety they had experienced in practice. However, what was not clear to me was the extent to which staff, both in the academic and clinical environment, felt challenged by the students and each other on the subject and this gave food for thought. I felt that the topic was still sitting far too low on the list of learning and teaching priorities within the programme.

Around the end of the first year in these investigations, it was becoming clear that although students were identifying learning needs in developing cultural sensitivity, the mechanism for making significant changes in the curriculum could not be accommodated. Had it been possible, learning and teaching of cultural competence based on models which existed at that time could have been explored and introduced alongside relevant strategies. However, changes in module structure, learning outcomes and their impact on programme outcomes would all have needed to be reconsidered, and held implications for considering revalidation of the programme. However, although I had little experience of teaching the topic, I felt that there were relevant areas which could still be effectively assimilated within the curriculum. Therefore, I took the decision to adopt a case study approach where I felt that I would be able to negotiate time to offer students learning in this area and its inclusion had been endorsed by the curriculum development committee. I also knew that I would be involved in teaching these same students in the two years ahead. In addition, I also did not wish the findings from the questionnaire to be lost and for students who had taken time to complete it to feel that their concerns would not be addressed. However, and probably more importantly for me, I saw the opportunity to continue developments in the learning and teaching of cultural competence within the curriculum as an important part of the students' professional development.

CHAPTER 6 CASE STUDY – YEAR TWO

Students entering the second year of the programme were expected to achieve learning outcomes identified in the Programme Handbook based on grounding in basic sciences, clinical sciences and physiotherapy skills and an explorative and analytical approach to study from year one. The aim in this year was to 'provide a learning environment where students [could] develop competence in professional practice and an analytical framework in their consideration of health care issues' (University of Birmingham, 2002).

6.1 Teaching input and feedback

The second module in the programme in which topics relating to cultural competence were taught was the Clinical Studies module, a 10 credit module in year two, and term two of the programme (see Figure 5 and Appendix 10). This module formed the bulk of the teaching on cultural competence in the curriculum and one of five of the learning outcomes was for students to 'explore issues of race and culture in the context of practice'. Another required the students to 'reflect on learning in the clinical modules'. The syllabus content for the module included 'health care in a multicultural society'. The module was taught over seven weeks in the second semester of the second year with an allocation of 50 hours. By negotiation with the module team, 21 of these hours were dedicated to the topic of cultural sensitivity. Formal assessment for the module was by submission of a 1000-1500 word learning contract accompanied by an experiential learning analysis of 1000-1500 words.

Development of a schedule for the teaching for the topic 'cultural sensitivity' in the second year of the undergraduate programme in the Clinical Studies module (see Figure 5) was founded on the results of enquiry in the study by Clifford et al (1999) and supported by the curriculum development committee. Findings from QT1 were also influential in its development. A schedule of the sessions may be found in Appendix 11.

Figure 5 School of Health Sciences – Physiotherapy Clinical Studies module timetable

DATE	SESSION	TUTOR	SEMESTER WEEK
FEBRUARY **Monday,** 2.00–5.00pm	Introduction to the Module Reflective Practice	Lecturer	Week 2:4
Thursday, 2.00–5.00pm	Learning Contracts	Lecturer	
Monday, 2.00–5.00pm	Independent Study	Lecturer	2.5
Thursday, 2.00–5.00pm	Cultural Sensitivity	Researcher	
Monday, 1.00–4.00pm	Learning Contracts	Lecturer	2.6
Thursday, 2.00–5.00pm	Cultural Sensitivity	Researcher	
Monday, 2.00–5.00pm	Visits?	Researcher	2.7
MARCH **Thursday, 1st**	Cardiorespiratory practice	Lecturer	

DATE	SESSION	TUTOR	SEMESTER WEEK
Monday, 2.00–5.00pm	Cardiorespiratory practice	Lecturer	2.8
Thursday, 2.00–5.00pm	Quality and Audit	Lecturer	
Monday, 2.00–5.00pm AWAY DAY	*The Professional Development Diary*		2.9
Friday, 9.00–12.00pm	Ethics	Lecturer	
Monday, 2.00–5.00pm	Audit	Outside Speaker	2.10 (Outside Speaker)
Friday, 9.00–12.00pm	Cultural Sensitivity Visits and Projects	Researcher	
Monday, 2.00–5.00pm	Cultural Sensitivity	Researcher and Outside speaker	2.11 Outside Speaker
Thursday, 2.00–5.00pm	Cultural Sensitivity? Visits and Projects	Researcher	

FRIDAY 9-11am
Please note that this session is timetabled as Research Practice 1. Everyone is required to attend in order to provide feedback on the visits, the projects and the modules. Your year tutor would also like to meet with you all. Thank you.

Since the term cultural sensitivity was already in common use within the programme, the decision was taken by the module team to use it throughout the timetable. Other topics explored within the module included reflective practice, learning contracts, cardiorespiratory practice, quality, audit and ethics.

Where sessions are identified as ‘cultural sensitivity’ in Box 5, the content of those sessions is outlined in Appendix 11.

Box 5 Outline of content on cultural sensitivity

Session 1 – Familiarisation with objectives, developing awareness, clinical issues, identifying areas for personal development Session 2 – Examination of a Eurocentric perspective, increasing awareness of identified groups Session 3 – Engagement and discussion of culture and lifestyles, visits Session 4 – Visits and project work Session 5 – Presentations, professional stance on equal opportunity issues Session 6 – External speakers Session 7 – Presentation and discussion of projects, module evaluation

In relation to the teaching of cultural sensitivity, students were required to recall learning and teaching which had begun in the first year, in particular introduction to the topics of race, ethnicity and culture within the IBR module. They were given an outline of the forthcoming sessions and reminded of the questionnaire which they had completed approximately one year previously. They were informed that comments from these would be taken on board. Feedback had indicated that students wanted greater assistance when working with individuals who were unable to speak English, using interpreters, improved educational input from the University and resources to help them in addressing cultural sensitivity. In planning the sessions and in discussion with the module team, attempts were made to address these issues.

6.2 The feedback form

A development from session one in the Cultural Studies module (see Appendix 11) was that students were asked to identify and to discuss their clinical experiences with minority groups in small groups. Following this activity, students were invited to each complete a short feedback sheet entitled ‘Clinical Experience with minority groups’ (see Appendix 12). Students were invited to submit the completed forms, anonymously if they so wished. From a group of 45, 30 questionnaires were handed in. Initial reading of these forms was used to help me steer further teaching and discussions with the students within the module. Fuller and more formal analysis and evaluation of this material for the study is reported here.

Purpose and justification

Although the clinical experiences of students with minority groups were being explored in other ways within the module, the feedback form ‘Clinical experience with minority groups’ provided the best capture of the data at that time (see Appendix 11). This item of enquiry at this point in the student journey was introduced as a way of seeing whether there had been any major changes since they had completed QT1, but more importantly to find out what they perceived their problems to be. It gave them opportunity to explore situations involving minority groups in the workplace and was centred on the challenges they faced, availability of resources, identifying outcome measures of performance and remaining individual concerns. The form was adopted as a learning and teaching tool and it was not an uncommon way for teachers to gain the views of their learners.

Areas exploring the students' clinical experience with minority groups may be found in Box 6.

Box 6 Clinical experience with minority groups

1. Identify the individual/situation by culture/ethnicity (no personal names)
2. Identify the medical request or situation
3. Outline personal involvement
4. Identify challenge
5. Give the resources that were available to you to deal with the issue
6. Are you aware of any other resources?
7. Impression of overall management with the individual
8. Remaining concerns

Reasons for asking students about point 1 were in order to elicit an identified person with whom they could identify relevant practical issues. Through class discussion, I felt that they were also now more familiar with terminology and so the term 'minority groups' offered them scope to think more widely i.e. beyond ethnicity. Point 2 required them to identify the medical request or situation which might explain their involvement or where they got involved. Point 3 honed in on their own personal challenge in that situation. In year one, students had overwhelmingly cited a lack of resources as an issue and I wanted to find out how they now viewed the situation, therefore points 5 and 6 were set to explore this. The hope was that students were becoming increasingly reflective in approaching practice as this was being taught in other parts of the module and in the programme, and that this would lead them to consider overall management of

individuals in practice. Therefore, points 7 and 8 challenged them to reveal their concerns.

Findings from 'Clinical experience with minority groups' feedback form

Thematic analysis was used to analyse the data in a similar way to the approach to some of the analysis conducted on the interview data in Chapter five in order to identify the main issues.

A summary of examples of the topical issues from the responses may be found in Table 7. The medical requests identified were for individuals with strokes, cognitive impairment, morbid obesity, fractures and orthopaedic conditions. In situations identified by culture/ethnicity, students included service users who were Punjabi, Italian, Welsh speaking, elderly Muslim, Afro-Caribbean and visually impaired patients. They showed some commonalities in the challenges they had encountered although medical requests and situations varied depending on where they were working (see Appendix 11). Their personal involvement included physiotherapeutic activities such as carrying out passive movements, facilitating and re-educating balance, assessment and gait, postural drainage, gait re-education and massage.

Table 7 Summary of issues arising with minority groups in clinical experience

	Topical Issues				
Challenges	Language (n=15)	Custom (n=6)	Cognition (n=3)	Physical problem (n=6)	
Resources	Interpreters/ Translators (n=11)	Clinical Educator (n=13)	Other (n=11)	Family (n=9)	Guide-lines (n=5)
Remaining concerns	Language problems (n=11)	None (n=10)	Personal development (n=5)		

Numbers in brackets indicate the number of students who identified the issues from the 30 feedback forms obtained.

Discussion and action

Students identified language and communication as their main area of concern but indicated that they used a range of resources to overcome some of the difficulties. Use of their clinical educators and other clinical staff was evident as was their use of family to act as interpreters. There is concern that family members were acting as interpreters. Good practice guidelines suggest that where this occurs in practice, it has the potential to breach user autonomy and confidentiality and so the issue was addressed with the students during the course of discussions within the module. It was an issue which was later reiterated by one the external speakers within the module. The challenge of communicating with patients who did not speak or spoke little English left some of them feeling unsure of how they

might manage similar situations in the future since specific concerns raised were often only partially met. For example, even though they had the assistance of staff and family, some felt that problems still remained in relation to the effectiveness of their assessment and treatment.

Students also identified situations of feeling challenged in evaluating ethically inappropriate behaviours and managing embarrassment when they met unexpected situations. I tried to address some of these anxieties through discussion within the module and offered some reassurance that as they went through the module there would be further opportunity to address and explore them with others.

Illustrative extracts from four of the student responses are offered below.

Student 2 Working with a 'Punjabi speaking lady'

> *I think the problem with language barrier will get better as the younger generation acknowledge the need for English in its basic form. Unaware of any resources except interpretation.*

Student 19 Treating Asian lady with stiff neck and upper back (revealed a dagger on her torso)

> *quite shocked at first – nervous anyway as was one of my first patients but managed to hide shock, also she lay face down so could not see my shock. Did not feel threatened as knew it was part of her religion but would have appreciated prior warning from educator...*

Student 21 Treating a 12 year old Muslim girl in a gym (restricted exposure of body)

Not as efficient as I would have liked treatment to be but it was a compromise at the time. Looked at leg in private before and after treatment. I'm not sure of how I could have handled the situation any differently or better.

Student 26 Treating a young patient with head injury and lack of sexual inhibition

Very difficult to tackle, I found it very embarrassing especially as the patient wasn't my patient and so I didn't feel like I could stand back and say no I'm not happy with that. Difficult as the patient was my age. I don't know that I would be able to deal with the situation more appropriately if I came across it again.

This last example was illustrative of the fact that students were seeing individuals with learning difficulties as a minority group and some of the associated challenges.

Other concerns as expressed by the students were focused around physical challenges in carrying out some tasks, for example managing patients who were overweight and their personal professional development. Issues around the latter related to the recognition of gaps in their development. It was assumed that the ten students who failed to identify any 'remaining concern' either did not have any, were satisfied with the outcome of how the situation was managed or just failed to answer the question.

Further teaching input – visits project

Based on student responses to QT1, the literature and discussions with other members of the team and information gained about their clinical experiences, increased interactions with minority groups was considered to be one of the most

important activities for the students to pursue and as such it covered a substantive part of the sessions in this aspect to the module. Feedback from the study by Clifford et al (1999) which was based on the experiences of previous students also supported this move. One exercise incorporated planned interactions with different groups where identified aims and factors were devised (see Figure 6). These community visits were organised with assistance offered by the Trust. The type and scope of the visits were varied and included a centre for Asian women, an inner city elderly day care centre, a rehabilitation centre catering for mixed communities, a Refugee Council establishment and a multi-ethnic women's group (see Figure 6). There was also a planned visit to a Gurdwara for those students who had not been included in other scheduled visits in order to ensure that all students were involved in an intercultural experience in which they had little familiarity. Appropriate instructions and guidance were offered on dress codes and customary practices. Students had the opportunity to speak, interact and familiarise themselves with the day-to-day activities of the people they met. Following the visits, student experiences were captured in the accounts from the visits (see Appendix 13).

It was also considered appropriate to include and invite external speakers who could make additional contribution to the discussions in religious practices and on the use of interpreters as part of the student experience. Invited speakers offered an overall and personal perspective on these themes.

Figure 6 Visits – Students investigating minority groups project with accompanying factors to consider. Adapted from content of Clinical Studies module

CLINICAL STUDIES MODULE
Students Investigating Minority Groups

Group 1 The Hearing Impaired 4 students
Group 2 Rastafarians (1) 4 students
Group 3 Muslims (1) 4 students
Group 4 Wheelchair users (1) 3 students
Group 5 Sikhs (1) 4 students
Group 6 Rastafarians (2) 4 students
Group 7 Visually impaired (1) 4 students
Group 8 Visually impaired (2) 4 students
Group 9 Jews 3 students
Group 10 Hindu 3 students
Group 11 Wheelchair users (2) 4 students
Group 12 Muslims (2) 3 students

Key
() Indicates number of groups
(See factors to consider below)

CLINICAL STUDIES MODULE – CULTURAL SENSITIVITY
MINORITY GROUPS (PROJECT)

STUDENT ACTIVITY – FOR EVERYONE

Factors to consider:

- *Origin/s of the group to which the individual belongs*
- *Dress code*
- *Considerations for subjective and objective assessment in physiotherapy practice*
- *Health behaviours*
- *Religion*
- *Language/communication*
- *Home visiting*
- *Hands-on care/treatment*
- *Naming systems*
- *Special considerations e.g. burial, diet etc.*
- *Implications of culture/lifestyle for physiotherapy practice*

It would appear that from the ‘Students investigating minority groups’ project (see Figure 6) these small projects and visits had enabled students closer interaction with minority communities and that students had actively engaged. Feedback from the visits indicated that not only had they provided rich experiences in furthering student understanding of minority groups but students had formed useful contacts and were able to produce documentation of items gleaned from the projects which were shared with other student groups on their return to the classroom. The Trust and University had afforded opportunity for exploration beyond their normal cultural boundaries to which students had been previously exposed on the course. Further evaluation of their experiences in this module and how it is thought to have contributed to the undergraduates’ perception of cultural competence will be explored in the final discussion.

Incorporating visits assisted in remedying this deficit and although planning, organisational and other logistical factors made it difficult at times, the positive responses of the students demonstrated that it was a worthwhile task. There was overwhelming endorsement by the students in their feedback for increasing the level of this type of activity. In developing cultural competence, the means by which physical interaction with different cultural groups becomes an inherent part of programme outcomes, and not just a classroom or theoretical examination, is an important issue. Writers such as Wood and Atkins (2006) and Larson et al (2010) promote immersion of students in different cultures overseas in order to develop cultural competence. However, travelling overseas to gain this experience is a prohibitively expensive option for some students and immersion can be

achieved if students stay more locally. It has been shown in this study that sufficient depth and breadth of experience may be gained in choosing appropriate local contexts which challenge students' learning when they were exposed to less familiar cultural practices.

Attempting to report and to capture the total learning and teaching experience which occurred in the Clinical Studies module would be an almost impossible task. However, in an attempt to give true flavour to developments, in addition to the above, Appendix 11 offers a schedule of the teaching sessions along with objectives which the students were expected to achieve. Learning and teaching strategies were varied and included facilitated whole group and small group discussions, project work and presentations, critical analysis, reflections and student exploration of different cultural groups and use of external speakers. Wherever possible, new learning was used to build on the past experiences of the student in both practical and clinical settings. The requirement for students to pursue independent study in addition to the contact hours identified in the curriculum was guided by suggested reading and further activity in relation to topics shown in Box 5.

6.3 Assessment of the module through personal accounts

The impact of the teaching of cultural sensitivity in the Clinical Studies module was assessed indirectly by the formal module assignment – a reflective account. Although students could reflect on a 'cultural experience', there was no requirement to do so, i.e. students were at liberty to use any clinical scenario they

wished. I was one of the markers on the team and I identified that three cultural scenarios used by the students in their reflections included language and communication difficulties as the main themes.

Given the changes instigated in the module around the topic of cultural sensitivity, I considered it appropriate that additional feedback on the learning and teaching of this aspect of the module from the students should be sought. I collected this information through the use of personal accounts. I also considered it important to gain the views of other lecturing staff but this proved difficult since they had not been present within the classroom. Using personal accounts to gain informal feedback from students and staff was not unusual since it is considered good practice for both teaching staff to seek on-going feedback from their peers and for students to routinely offer their views. Additionally, the formal teaching evaluation form (see Appendix 14) was analysed and personal reflections from my researcher's log is offered (see Appendix 15) in order to gain an overall evaluation of the module.

Purpose and justification

The submission of personal accounts was seen as a way of giving individual students a means by which they could offer their personal views of their experience within the Clinical Studies module in relation to the learning and teaching of cultural sensitivity. I considered that it was important that each student was afforded this opportunity as autonomous learners. Personal accounts were also a means to assess whether stated learning outcomes had been achieved The

intention was that feedback from these accounts would offer useful information which might inform the learning and teaching of the topic in the future.

Personal accounts as a method of data gathering

Gaining feedback from students is a commonplace occurrence in learning and teaching in undergraduate programmes. It is recognised that the task of finding true meaning from feedback or written accounts depends on a number of factors including formulation of explanations given by students and interpretation of them given by the researcher (Cohen et al, 2011). Nonetheless, their strength lies in the distinctive insights which they give that are generally live and authentic (Thody, 1997).

Development and administration

I took the decision to request personal feedback through ten-minute reflective pieces of writing from the students in order to gain personalised views of the teaching. They were requested to write these, without discussion with peers, in the final session of the module. I offered topics on which they could base their reflections, for example time spent on the topic, usefulness and experiences but they were told that they were at liberty to devise their own topics and that these were mere suggestions.

Forty-two students submitted their hand written reflections on A4 sheets of paper. Although there were 45 people registered in the cohort, three were absent and

while anonymity was requested, five students gave their names but these were erased.

Data preparation and analysis

All of the scripts were coded and converted verbatim into typed electronic text format in order to facilitate thematic analysis. This approach helped to increase my familiarity with their content, a process which is often deemed valuable by qualitative researchers (Moule and Goodman, 2009). Data within the accounts were organised into categories and themes, aided by the use of highlighter pens of different colours and the 'find' facility in Microsoft Word. This process of categorising the data and thematic analysis was similar in outline to the approach adopted in analysis of the interview data (see Chapter five).

Although these personal accounts or feedback on the learning and teaching of cultural sensitivity were completed and submitted in the second year of the programme, only an initial analysis was completed at the end of the year since it was not part of the formal module evaluation. Final evaluation of the data was completed by the end of the programme where themes from the accounts were compared with data that emerged from other areas of investigation within the study (see Chapter eight). However, to offer insight into the student feedback on the learning and teaching experiences of cultural sensitivity within the module, findings are offered here.

Thematic analysis of the personal accounts was undertaken (in a similar way to that conducted for the interview transcript) and analysis of the content and themes verified by an independent investigator.

Findings

The main themes are offered in Table 8. These were identified as covering issues related to use of outside speakers, time spent on parts of the module and its usefulness.

Table 8 Items/themes given by students in their personal accounts

Items/themes	Number of Respondents
Outside speakers	29
Visits	25
Module importance/usefulness/interest	24
Too much time	22
Suggestions	21

The number of individual responses related to outside speakers, visits, the importance of the topic, time spent and suggestions for the future gave an indication of the strength of feeling. The quotes below were selected to illustrate common themes which emerged from the accounts.

> *Personal account (Student 1)*
> *Found most aspects of the cultural sensitivity studies very interesting and useful to clinical practice. However, I did feel that too much time was allocated to cultural sensitivity with the clinical studies module. I enjoyed my visit and found it interesting to experience a different culture. I feel that cultural sensitivity is an important aspect in clinical practice and it may be more useful to gain more knowledge of different cultures within this module. Although a large amount of time was allocated to clinical sensitivity, I think that I still have a lot to learn about different cultures. It may be more useful to spend time thinking about different cultures and their relevance to clinical practice i.e. how different beliefs will actually affect physiotherapy.*

Personal account (Student 23)
Time given – Sufficient time was given to the cultural part of the module. Students need to be encouraged to explore other aspects further as it is impossible to learn everything about every culture.
Experience – The talk by the outside speaker was very interesting if not a little confusing at times. The latter point related to Asian names, which I felt was over-explained. The cultural quiz raised a great deal of awareness within the group and was interesting how culturally diverse the world is.
The visits were very interesting and informative. The people at the temple were kind and warm and deserving of equal respect.
Usefulness – In this ever culturally diverse world the need to gain appreciation is very important.
Contribution to course – As trainee health professionals being able to understand and treat different cultures appropriately is extremely valuable. The course strongly focuses on this aspect of 'the real world'.
Changes/Suggestions – Perhaps an information pack to cover the main religions in the UK e.g. - Jewish, Sikh, Hindu, Christianity etc. to provide a basic grounding on which to develop knowledge and appreciation of these religions, faiths or 'way of life'.

Personal Account (Student 28)
Time: I feel enough time was given to all areas of the module.
Experience: I feel the clinical visit was a very valuable experience to undertake. It provided a rare insight into another culture that could not have been gained from any other source i.e. lecture or media.
Usefulness: As a module in its entirety, I feel it was useful and beneficial in highlighting areas many people may not have thought about until prompted.
Contribution: I feel the module is valuable in terms of the curriculum as it provides key knowledge and information that is beneficial for 'us' as therapists when we are practising. It allows us to understand the social background of our patients and enable us to treat them or advise them more holistically.

Personal Account (Student 35)
Adequate time was given to this module, in order to make it both interesting and relevant. Through both outside speakers and through the cultural visit I attended, as well as the discussions in class, I feel I have learnt a great deal about various cultures in and around x. I feel better equipped to handle certain situations that may involve delicate cultural issues. This increased knowledge of different religions and groups has made me more aware of the patients' willingness to comply with various treatments and the reasons behind this. I think cultural

> *studies have a valid place in the curriculum being a very important part of clinical practice especially in cities such as x. I think most people enjoyed the topics and issues brought up during the module, learning a lot. More outside speakers from varying cultural groups would be beneficial.*

Feedback identified that some students felt that too much time had been spent on some topics as reported in 22 of the accounts. It was not clear whether these general criticisms were of individual sessions and/or of the topic as a whole but seven students identified specifically that they felt too much time had been spent on 'the topic'.

Of the 31 people who gave suggestions for improving the module, seven requested further visits, nine – more speakers, seven – less time and two – more time. Other requests were for hand-outs, reorganisation of the time and greater integration of the topic into other areas of the course. Five students felt that it gave them increased confidence in dealing with minority groups and that it helped to avoid causing offence. One student felt that it was not an important part of the curriculum; the comment made was that the module 'was useless for developing their physiotherapy skills since most have a good cultural awareness without having it spelt out for them'. Discussions of these accounts are considered below in discussions on teaching input below.

6.4 Module evaluation

Formal module evaluations conducted via a 'Course and Teaching Evaluation Form' formed a normal part of the feedback mechanisms within the programme

and was used to inform part of the review of the module. These forms are normally kept in house but verbal permission was given by the School for the use of this data within the research with due regard to anonymity (see Appendix 14). The form was administered at the end of the module.

Data collection and analysis

Forty two responses were received for the formal evaluation of teaching within the module. All aspects of teaching contained within the module formed part of this evaluation; therefore, as previously indicated, it was difficult to pin-point where feedback was specific to the learning and teaching of cultural sensitivity. However, fifteen students confirmed that 'time management' was an issue within the 'reason for rating' section, and four of these comments were related to cultural sensitivity. Overall responses to the items were positively rated, in particular there were 37 agree/strongly agree responses to 'all lecturers were well prepared for their teaching sessions', 33 agree/strongly agree responses to the lecturers facilitation of students' independent thinking and independent study and 32 agree/strongly agree responses regarding sufficiency of the information which the module provided.

Figure 7 Clinical Studies module evaluation

Module Summary – Clinical Studies
Module leader Mel Stewart
Other lecturers: 3

Relationship to other modules
This module draws on the content of other modules and the students' clinical practice in developing their ability to reflect on the practice of physiotherapy in the current health care context. (The main topics include: portfolio development, cultural sensitivity, clinical audit, and ethics).

Assessments
Clinical Studies Assignment (experiential learning and learning contract analysis). 46 Passes (no fails)

Student evaluation
There was general satisfaction with this module. However, from the comments submitted, students found a few of the topics 'drawn out' and would have preferred to have spent less time on them.

Staff comments
The students gave the impression that they were interested and engaged well with the topics but their willingness to apply theoretical principles in the study of ethics was less good. In the cardiorespiratory sessions, all groups produced and presented posters which were considered to be of a high standard. The sessions linked well with the ITP module. The time allocated to certain topics requires reconsideration.

Analysis
Comments from staff and students would suggest that this module was well received. The time devoted to health care in a multicultural society and valuing diversity was extended at the time the module was being delivered due to less time being required in certain other areas of the module. These changes require discussion.

Suggestions for the future
It is important that the time allocated to certain topics is reconsidered and discussed with the appropriate staff before the start of the module. Some of the changes to the module have been incorporated into the professional development module of the new course. The comments made by current staff and students will be addressed both for the 2000 cohort of undergraduate physiotherapy students and the x undergraduate physiotherapy and nursing students.

The learning outcomes for the Clinical Studies module were that the students should have enhanced ability to reflect on learning in clinical modules, contribute to cycles of quality and audit, explore issues of race and culture in the context of practice, make ethical decisions in the context of practice and follow concepts of task delegation and supervision. It is clear that there was a mixture of learning outcomes to be achieved and areas of overlap. All students were successful in achieving the outcomes as measured by their success in passing the required experiential learning assignment so it may be assumed that they were successful in the learning outcome in their 'ability to explore issues of race and culture in the context of practice'.

Discussion and reflection on teaching input and feedback

It was clear that the majority of the students felt that their learning and teaching experiences within the Clinical Studies module had been overall a positive one. The emergent themes from their personal accounts highlighted that students placed emphasis on the value of 'outside speakers' from different cultures, visiting different cultural settings and the importance of these as major contributors in the development of their own cultural sensitivity. The cultural, ethnic and religious backgrounds of the students were typical of previous cohorts and cohorts who followed in that the majority identified themselves as white British/English and this factor has to be considered in light of their feedback and the limited exposure to other cultural groups which they identified. They had also acknowledged within the questionnaire that they had little awareness of many of the ethnic groups present

in the locality in which they had carried out their clinical work (see Findings from QT1). Analysis of their feedback suggests that use of external visits was a useful way of increasing their exposure to different minority groups and that the experiences had been positive. It would seem that challenges which arose were also viewed in this way.

The decision to include cultural sensitivity within this module and responsibility for leading the module and the topic was a curriculum decision made through the normal channels of curriculum planning, delivery and organisation within the programme. It is not uncommon for the main drivers for inclusions to curricula to be those who are most enthused about the topic. Therefore, the influence of this factor and personal biases in consequent delivery needs to be considered within the analyses. It appears that the allocation of the appropriate time to specific learning and teaching experience required some shift in emphasis and my personal emphasis on the importance of certain topics could have been a factor.

Three other members of the lecturing staff assisted in the development and implementation of the module. With hindsight it would have been helpful to have gained more of an outsider view of my performance from one of these colleagues, even though they had not been present in the teaching sessions. However, verbal feedback was obtained on one of the sessions as I noted in the excerpt below from the researcher's log book. Unfortunately, the written feedback requested was never received.

Excerpt from the researcher's log book:

> *Session with subject group – Minority Groups – Assumptions and attitudes. Colleague invited to observe, comment, participate to provide written feedback. Brief verbal feedback suggests students find it difficult to deal with [and] lack the skills to deal with some of the topic. Long session – 2hrs 45mins*

Reflection

Scrutiny of lecturers' performance in higher education is normally based on a number of factors (Hoffman and Oreopoulos, 2009). These may include student feedback, peer review, module and programme evaluation and student attendance. In respect to the Clinical Studies module, feedback on my own performance was deduced from student evaluation, module evaluation and limited feedback from peers. However, I feel that the day-to-day interactions which were less open to formal reporting were equally important. I considered the ease with which students felt they could bring their problems into the open in order to share them with me and fellow students were critical to their learning in this part of the module. Information leaflets, guides and experiences which they brought back from their visits assisted in alerting me to the scope of the challenges with which they are presented. Similarly their reported clinical experiences with diverse groups continued to highlight challenge in practice. An attendance register was kept for each session and attendance was generally over 90 percent and so the majority of students were generally present to explore the learning experiences which were offered.

I was a little disappointed to read that some of them felt that too much time was spent on the topic, partly because of my own interest in developing learning and teaching in this area, but recognised that this was important feedback on which to consider the student perspective and a timely reminder not to get too focused on my own interests. Subsequent analysis of my teaching and overall evaluation of the module has led me to the conclusion that there was indeed repetition, more than I realised at the time and that a more rigorous schedule of activity, identified topics and further investigations into other areas of the curriculum prior to commencing the programme may have avoided some of this negative criticism on time. I also gave consideration to other learning and teaching strategies for the topic which I might adopt in the future and these are followed up in the main discussion.

There were no further identified ways within the curriculum which exposed students to the topic of cultural competence other than those previously mentioned. The recognition that it was considered to be an important part of the course and should be embedded meant that if I were to follow the students' journey in relation to the topic, then I needed to find areas and opportunities where the topic could fall naturally into the curriculum and where I was already suitably placed to explore its learning and teaching. In the second year of the programme, one of the two modules which ran simultaneously alongside the Clinical Studies was Research 1 module in which I was a part of the team. This meant that my association with the students continued through this module. The opportunity was presented where I could keep the topic on their agenda and maintain a case study

approach to follow their journey. Mixed methods case study allows for the inclusion of investigations which might assist in answering the research question. I considered that the use of repertory grids to gain an in-depth understanding of students' constructs of cultural competence at this juncture in their programme would be illuminating.

6.5 Repertory grids

The repertory grids were used as part of the investigations into undergraduates' perception of cultural competence and associated perceptions of clinical competence. This investigation was conducted in the second year of the course within the Research Practice 1 module (see Appendix 4). All students had experienced one clinical placement of four weeks at the end of the first year of the course.

Repertory grids as a method of data gathering

Since the method was first devised by George Kelly, the use of the grids as a means of 'getting into the minds' of the subjects has been used in science, education, medicine, business and an array of other areas (White, 1996; Wilson and Retsas, 1997; Marsden and Littler, 2000; Hankinson, 2004). In his book entitled 'The Psychology of Personal Constructs', Kelly (1955) describes the personal constructs of people as basic units of analysis. He states that each individual has access to a limited number of constructs and these basic units are open to investigation. Constructs are used by individuals to evaluate or construe

the phenomena or elements that make up their world. The phenomena may be people, events, ideas, situations etc. and are commonly referred to as ‘elements’ in the grid. The extent to which individuals are similar or different in their constructs may be an indication of the similarities and differences of previous exposures to events, relationships or environments.

A number of different grids have been devised over time but they all have essentially two characteristics, on the one hand there is the construct under investigation while on the other there are the elements individuals employ in order to conceptualise aspects of the world. Constructs may be similar to attitudes but unlike the latter, they may not have an emotional evaluative component and may be merely a descriptor, for example clean/dirty (Fransella and Bannister, 1977). The grid may be used as a formal way of demonstrating the mathematical relationship between these specific constructs, normally offered as adjectives, and as elements by the people construing them (see Appendix 16). Constructs can be very wide in concept or very narrow since they reflect individual personal experiences. In this study, cultural competence and clinical competence were the constructs under investigation and the elements were people as identified by the students.

One of the advantages of repertory grids is that they are extremely flexible and therefore may be applied in settings such as the classroom. Although their analysis varies from being relatively simple to complex, the data can be managed in a number of ways and the development of different computer software

packages has contributed to further possibilities (Scheer, 20079). A further advantage lies in the way the researcher may attempt to ‘look into the minds’ of the subjects, with minimal contamination in the production of the data. A vast amount of data may also be generated from one individual and subjected to techniques of analyses where previously the techniques could be applied only to groups of subjects, for example cluster analyses, t-tests of group differences and correlational methods (Fransella and Bannister, 1977).

Repertory grids have been used in nursing to elicit a number of constructs. For example, constructs have been elicited in studies by Wilson and Retsas (1997) for effective nurses, White (1996) feelings in clinical practice and Morrison (1990) on perceptions of caring. In occupational therapy, Kuipers and Grice (2009) concluded that it was an effective tool for exploring clinical reasoning based on their capacity to access personal frames of reference and elucidating meaning and structure which supports clinical reasoning. Within physiotherapy their use has been less noticeable, although Cross and Hicks (1997) used them to reveal criteria used by clinicians to differentiate between good and bad clinical performance in undergraduate physiotherapy students.

The method in this study employed a ‘static’ as opposed to a ‘dynamic’ approach as described by Alban-Metcalfe (1988). In the latter a repeated application can be used to indicate changes in perception over time. In this static study the exercise was not repeated at a later date. It was important that subjects were given the opportunity to elicit their own constructs of cultural competence and to identify the

elements (people) that were important in the elicitation of those constructs. This process is central to personal construct theory although in some forms of the repertory grid technique, constructs may be provided for the subjects. The processes of laddering or pyramiding (i.e. posing ‘why’ and ‘how’ questions to elicit further meaning), questionnaires and open-ended interviews can also contribute to the 'spirit of personal construct theory' (Wilson, 1992). Although these methods were not employed, the grid was not viewed as a stand-alone investigative method but one which might be strengthened by other approaches to the research.

Introduction of the topic of repertory grids to the students was blended into an existing module – Research 1 module (see Appendix 4). The module already existed as the medium through which approaches to research were taught. Repertory grids were introduced as one of these approaches. Completion of the grids was used as a practical and participatory learning tool.

It is often said that the grid is a method not a test and therefore has all the problems one might expect in constructing an experiment (Fransella and Bannister, 1977). Hence, precautions were taken to avoid the danger of using the grid as an instrument without the accompanying evaluation of the process of construing and an evaluation of the process is offered in the discussion.

In pursuing case study research, it was recognised that the practitioner continues within practice without interrupting the flow of the overall learning and teaching experience wherever possible; therefore, embedding learning and teaching of

repertory grids within a relevant context was important. Students were appropriately informed that the data collected was potentially part of the research investigations into cultural competence but that all data would be anonymised. Careful consideration was given to instances where students might not wish to have their data entered into the data set and this was addressed.

Purpose and justification

In conducting a repertory grid survey, I hoped to examine how physiotherapy students construed their understanding of cultural competence. Alongside this, the concept of clinical competence was introduced as an additional item within the investigation for two reasons. I postulated that students had greater familiarity with the term ‘clinical competence’ and that by including it as a term, it would help to clarify how grids, when used with a topic with which they were familiar, could be used to generate research data. People also tend to have more constructs around topics they know well (Kuipers and Grice, 2009). However, one group completed the grid for cultural competence first; this was a factor in how the grids were evaluated and this is discussed later. A second reason for introducing the topic of clinical competence is that there is an untested assumption that practitioners who are clinically competent are also deemed to be culturally competent. Therefore, it was opportune to investigate this from the students' perspective since data regarding the two competencies could be collected simultaneously. Constructs within the grids are viewed as representative of an individual’s thinking. Students included themselves as one of the ‘elements’ in the grid, and therefore self-assessed competencies for each student could also be compared across the

cohort. The two grids, one for cultural and the other for clinical competence were completed by each student but in order to counterbalance for order effects, half of each of the group began the exercise using the grid of the alternative competence.

Although the investigation fell naturally into the Research 1 module, increased awareness that the students were 'subjects' of research and ethical implications were addressed (see Ethical Approval). Reasons for adopting repertory grids and how they might be included in the research process were explained and informal consent obtained from all the participants.

The grids were incorporated as a part of a mixed methods research approach and they generated both qualitative and quantitative data. For reasons given below, greater emphasis was placed on evaluation of the qualitative data in exploring students' constructs of the competencies, while evaluation of the quantitative data explored self-assessed ratings of their own competencies based on these constructs. Results from the quantitative analysis were examined for potential usefulness in development in learning and teaching.

In summary, the aims of the grids were to

- Identify how students construed cultural competence;
- Identify how students construed clinical competence;
- Compare student constructions of cultural competence and clinical competence.

Subsequent to the above:

- Identify how students rated their own cultural competence;
- Identify how students rated their own clinical competence;
- Compare how students rated their own cultural and clinical competence.

Administration

All of the participants received a grid template with a list of instructions (see Appendix 16). These instructions were also read out to them. The cohort was split into two groups – Group A and B and both groups completed the two grids. Group A (n=25) completed the grid relating to clinical competence first, while Group B (n=18) completed the same process but began with the grid relating to cultural competence. Completion of repertory grids can be confusing if insufficient time is given to the exercise. Due consideration was given to this and a record was kept of the difficulties that arose during the exercise. Each group took approximately one hour to complete the two. The opportunity for students to offer free rather than given descriptors of clinical and cultural competence was considered to be crucial to this study since the focus was on portrayal of their own personal constructs. As a consequence, a modified triadic repertory grid procedure was employed where individuals were asked to present their own adjectives, words or phrases with which to describe these two constructs.

In the construction of repertory grids, triadic, dyadic or monadic procedures are adopted to elicit different types of constructs. The monadic procedure is particularly valuable when one wish is to find out about a person's single central value and one vivid dramatic situation is used to elicit the construct. In the dyadic approach, the subject is presented with two elements and asked to indicate important ways in which they differ or are alike. In triadic elicitation, three elements are offered and a contrast sought between two and one; the differing element identifies the contrasting pole. Generally, all the elements (people in this instance) are presented to the subject and the attributes they have in common are specified. In this study, students were asked to specify their own attributes; hence, the procedure is described as a modified triadic grid (Jankowicz, 2004).

As well as receiving a grid and a list of instructions, students were also provided with seven plain cards. Each student was asked to think of three people whom they would describe as 'good' in terms of their cultural competence (or clinical competence), and three who they would consider 'bad', and that they should include themselves as one of the people. They were informed that the elements or people elicited could be lecturers and/or practitioners within the workplace or within the School. They were instructed to enter the names onto six of the cards and to place them into two groups of three to represent 'good' and 'bad'. They were requested to use codes or initials for the names to ensure anonymity. Each student was then asked to focus on three individuals, two from one group and one from the other. They were then asked to consider and write down phrases or adjectives to describe how the two individuals from one group were the same as

each other but differed from the third in terms of their clinical or cultural competence. The two similar individuals were identified by a cross marked on the card. The word/s or phrases used to describe these individuals were written down on the seventh card. This exercise was repeated by each student using a combination of cards from both their ‘good’ and ‘bad’ group of three cards at random until they were able to produce at least ten adjectives or phrases. Individuals (elements) were then entered into the grid in a row as numbers 1-6 and the adjectives (constructs) were transferred into the first column of the grid as shown in Appendix 16. Using a rating scale of 1-7 where 1 equals not at all culturally/clinically competent, and 7 equals clearly culturally/clinically competent, students were asked to rate each of the individuals including themselves on each one the constructs listed. They were then asked to identify themselves in the grid with an asterisk. Therefore within the completed grid, each column represented an individual, while a row represented the construct and competence assigned to the six individuals chosen by each student including themselves.

Since the students were unfamiliar with the term cultural competence and they experienced some difficulty completing the exercise, they were given a definition. It was defined as 'the ability to work across and within diverse groups in a positive manner'. Group B began with the concept of cultural competence, and so I was able to pre-empt some of the initial difficulties that arose later with Group A. Some students also appeared to have problems thinking of practitioners who were not competent. It may have been the case that in their view, all practitioners were expected to demonstrate competence.

Data preparation and analysis

There are a number of ways in which analysis of repertory grids are normally undertaken and these include frequency count, content analysis, examination of two elements with or without statistical analysis, cluster analysis, principal component analysis, statistical analysis using multivariate analysis and statistical analysis using dendritic analysis i.e. a combination of qualitative and quantitative analysis. The first three methods were employed in investigating and analysing the data. Correlations between constructs may be demonstrated through principal component analysis but in this instance it was not adopted since students were at liberty to choose their own elements (in this case people) and it was not possible to relate grids directly from one to the other. However, adopting frequency counts and content analysis meant that comparisons could be made between 'elements' and 'constructs' within and across grids. It had to be borne in mind that a grid with seven elements and ten constructs might only offer a glimpse of how the individual sees this complex aspect of their world. Adjectives offered by the students contributed to the formulation of codes, categories and themes for analysis.

In addition, grounded theory also offered a useful way of examining data from the grids. Grounded theory is a process which assists the researcher in building and generating theory through data analysis and to weigh up alternative explanations in relation to the concepts on which it is built. Since it was not known how students perceived cultural competence, the hope was that categories might emerge from the data. Grounded theory is a technique which grounds the data in the culture or context of the individual, and since individuals were at liberty to choose both the

elements and constructs in composing the grids, it was useful in exploring their personal world. Cohen and Manion (2011) identifies the mainstream intention of analysing qualitative data as the generation of grounded theory and its application in this investigation was with this in mind.

Computerised programs for administering and analysing grids are becoming increasingly available but at the time that the study was conducted, access was limited and it was decided that time would be more efficiently spent in conducting manual coding. Computer packages such as NViVo and QSRNUDI*ST could have assisted although they do not actually perform the analysis and the researcher still needs to decide and generate the codes and categories. Manual coding gave me the opportunity to identify errors in the coding more easily, not least because category preparation is crucial before inputting the data into a computer for analysis, although computer analysis could have been helpful.

The coding process

At the start of the process, each of the grids was transferred into a Word document in order to obtain an electronic record of the data and to assist manoeuvrability. A hard copy was made of all the grids and for practical purposes and to assist cross-checking, four grids were put onto one A4 page. Each grid was labelled with either A for clinical competence or B for cultural competence and a number to indicate the student completing the grid.

A sample of 24 grids, completed by 12 students was taken as a pilot to begin the initial coding. Aided by the 'find' facility in Word, highlighter pens of various colours, a pencil and a rubber a manual search for common adjectives or descriptors across the grids was undertaken. Grids were examined systematically, grid by grid, adjective by adjective and phrase by phrase. For example in examining the grids for clinical competence, terms such as 'knowledgeable' and 'good communicator' were commonly cited, so these words were highlighted on the relevant grid in a colour designated for the theme. A symbol such as an 'x' or 'o' was used when the colours had been exhausted and a 'key' to the colours and symbols was listed on a cover sheet. A second coder was employed to carry out a similar exercise independently, using copies of the same 24 grids (12 students) in order to assist in verification of the data. Both coders met to discuss decisions which were taken on coding and initial codes were compared.

Further decisions then had to be taken on the number of concepts to be coded, whether to code for existence or frequency of a concept, how concepts were to be distinguished, rules for coding, what to do with irrelevant material, how to code the texts and how to analyse the results; all of which would have implications about the truthfulness of the coding. There were strong similarities between the two coders but discussions and decisions took place on renaming, reshaping and coalescing the themes. For example, a category of 'open and accepting' incorporated a number of adjectives which included non-judgemental and unbiased. Similarly a theme of 'recognises and understands individuality' was adopted under the heading of caring. After completing this activity for the 24 grids,

coding of the remaining grids was continued by the researcher. Adjectives were drawn together and descriptors derived which were seen as indicative of the codes and which conveyed an explanatory and interpretative or analytical meaning to the grids. Where there was a poor fit, codes and categories were modified to take account of all the data. A process of constant comparison was pursued in which new data emerging from the grids were compared with existing data and with the categories which had been devised. Further meetings were held with the second coder to discuss final coding, the overall process and reasons for the decisions taken.

Findings

Derived codes for clinical competence

Forty-three participants, 90 percent of the cohort completed the grids. The sample included male (n=5), female (n=37). The main adjectives offered by the students describing clinical competencies are given in Table 9. Numbers given in the brackets identify the number of individuals stating that particular or similar adjectives. In general, the results from the grids on clinical competence across Groups A and B were similar with only one or two exceptions.

Table 9 Codes for clinical competence

Codes for Clinical Competence (n=subjects)	Adjectives used for Clinical Competence
1. Approachable/Has good interpersonal skills (n=39)	Approachable, friendly, good interpersonal skills, polite, considerate, adaptable to patient needs, sociable
2. Experienced (n=35)	Experienced specialist in area
3. Knowledgeable (n=30)	Knowledgeable, wide range of knowledge, wide knowledge base
4. Good communicator (n=24)	Communicative, succinct, gives clear instructions, communicates well with patients, explains things well, answers questions directly, good patient rapport, good listener
5. Confident (n=21)	Confident, confidence in work/ability
6. Caring (n=20)	Caring, puts patient at ease, able to empathise, makes person feel valued, considerate, interested in patient, sympathetic, empathise with patient, gentle patient handling, gentle/easy-going, listens to patient, sensitive, gentle
7. Professional, skilled, qualified (n=20)	Professional, able, technically sound, good diagnostic skills, skilful, wide variety of skills, skilled, educated, qualified
8. Enthusiastic (n=20)	Enthusiastic, passionate about work, hard worker, passionate about their profession, enjoy work, ambitious

The adjectives most favoured by students for individuals who were deemed clinically competent were: ‘approachable with good interpersonal skills’, ‘experienced’, ‘knowledgeable’, ‘good communicator’, ‘confident’, ‘caring’, ‘professional/qualified’ and ‘enthusiastic’. ‘Other characteristics’ included adjectives that described positive approaches to interacting with patients, having a personal touch and demonstrating a good standard of work. Occurrence and reoccurrence of these adjectives into codes were analysed by frequency count and percentages. Fifty-six percent of the students mentioned at least four of the

eight descriptive codes identified in Table 9 whilst 46 percent mentioned all eight. Therefore, the frequency in the use of specific adjectives meant that they could be retained as specific codes. Further analysis of adjectives across the grid was undertaken to develop codes which would take account of all the data and consideration given to including other characteristics offered.

Codes for cultural competence

A similar process of coding as described above was conducted with the grids for cultural competence. Table 10 shows the codes which were adopted. The term cultural competence was described as being ‘open/accepting’ by 86 percent of the students, whilst six further codes ‘caring’, ‘knowledgeable/educated’, ‘recognises and understands individuality’, ‘experienced’ and ‘believes in equality’ were mentioned by 30 percent of the cohort. Only a few students used exactly the same phrases for example, ‘acceptance’, (n=5) ‘not judgemental’ (n=4) and ‘experienced’ (n=3). Further consideration of the data showed there was scope to combine certain themes and adjectives.

Table 10 Codes for cultural competence

Codes for cultural competence (n=subjects)	Adjectives used for Cultural Competence
1. Open/accepting (n=37)	Open, not opinionated, not narrow-minded, flexible in treatment, open to new culture, aware of others' beliefs, flexible – will listen to and respect other ideas, not prejudiced, unprejudiced, adaptable, tolerant, not judgemental
2. Knowledgeable/educated (n=23)	Knowledge of a variety of cultures, culturally knowledgeable, educated in cultural issues, aware socially and culturally
3. Caring (n=19)	Caring, helpful
4. Recognises and understands individuality (n=14 – Group A)	Understanding, understands how culture can affect treatment, understands individual needs, sees people as individuals, understands individual needs of patients
5. Experienced (n=14)	Experienced, experienced working with a range of people, experience of working with different cultures, life experience
6. Believes in equality (n=13)	Equality, talks equally to patients, believer in equality, treats everyone equally, demonstrates equality
7. Respects others (n=8)	Respect for others, respects all patients, professional, sensitive, considerate

Initially ungrouped adjectives or cultural competence adjectives were later coded as signifying 'relationship to others' and then further interpreted to signify 'respect'. Consequently, this category was disassembled and reassembled under other relevant and existing codes. Deriving codes for the grouping of adjectives labelled initially as 'personal characteristics' were less obvious. Identified adjectives such as 'not ageist' and 'not sexist' had a strong association with 'beliefs in equality' while terms such as 'encouraging', 'tolerant', 'willing to learn about other cultures' could be associated with 'recognises and understands individuality'. The process of analysing the data and developing codes continued until all of the data were incorporated into the seven final codes identified in Table 10.

In completing the grids, the outcome of the exercise was similar between Groups A and B. However, during supervision I was asked many more questions about the topic of clinical competence by both groups. The same number of adjectives was produced by the two groups for the two grids but students required a greater length of time in which to complete the grid for cultural competence, irrespective of whether it was completed first or second. Analysis of the grids showed that a greater range of descriptions and more words were used for cultural competence than for clinical competence. It was also interesting to note that many of the positive or 'good' characteristics for cultural competence were written with the prefix ‘not’, for example not narrow-minded, not patronising and not judgemental.

Comparison of derived codes for clinical competence and cultural competence

It was possible to follow the process of grounded theory and to develop categories for the codes from the two competencies. Individuals who were seen by the students to be clinically competent were approachable with good interpersonal skills, experienced, knowledgeable, good communicators, confident, caring, professional and enthusiastic. Individuals who were culturally competent were seen to be open and accepting, caring, someone who recognises and understands individuality, is experienced, believes in equality, educated and shows respect. It was possible to formulate a single category for ‘experienced and knowledgeable’ from codes within both sets of competencies. This was useful since as Weber (1990) identifies, where possible it is preferable to work with categories as well as word counts when attempting to seek meaning. Similarly, making associations

between words and codes and categories including relationships between them is recognised by Cohen and Manion (2011).

In interpreting and analysing the grids, students indicated a clear differentiation between individuals who they viewed as clinically competent and those who they saw as culturally competent, and they used succinct adjectives to describe a clinically competent practitioner. The culturally competent practitioner appeared to have their main characteristics centred on particular moral dimensions; for example, equality and being non-judgemental, whereas clinical competence appeared to be centred on experience, knowledge and being approachable. Frequency counts were important in this study but it was borne in mind that they did not necessarily convey importance and that not stating something might be as important as what was stated.

Students self-assessed rating of their competencies

Students had the opportunity to rate their own clinical and cultural competencies and 41 of the 43 students took the opportunity to do so. Although this was not the main thrust of the study, analysis of this data afforded the opportunity to see where students positioned their levels of competence in relation to others. An overview of the quantitative analysis of their ratings within the grids is offered below. Scoring was out of a possible maximum of 70 (scores of one to seven on each of ten items).

Students rated themselves higher on their cultural competence than on their clinical competence (see Table 11). Out of a maximum of 70, the mean score for cultural competence was 52.15 with a minimum score of 32 while the mean score for their clinical competence was 42.2 with a minimum score of 18 and a maximum score of 58.

It was also worth noting that while the mode and median scores for cultural competence were 54 and 46, comparative scores for clinical competence were 43 and 35.

Table 11 Descriptive statistics of students' self rating of clinical and cultural competence

	Cultural Competence	**Clinical Competence**
Mean	52.15	42.26
Std. Error of Mean	1.34	1.52
Median	54.00	43.00
Mode	46.00	35.00
Std. Deviation	8.58	9.72
Variance	73.63	94.51
Range	34.00	40.00
Minimum	32.00	18.00
Maximum	66.00	58.00
Sum	2138.00	1732.50

To explore these differences in self-ratings of clinical and cultural competence, a comparison of individual scores was made.

Table 12 Comparison of individual scores for clinical and cultural competence

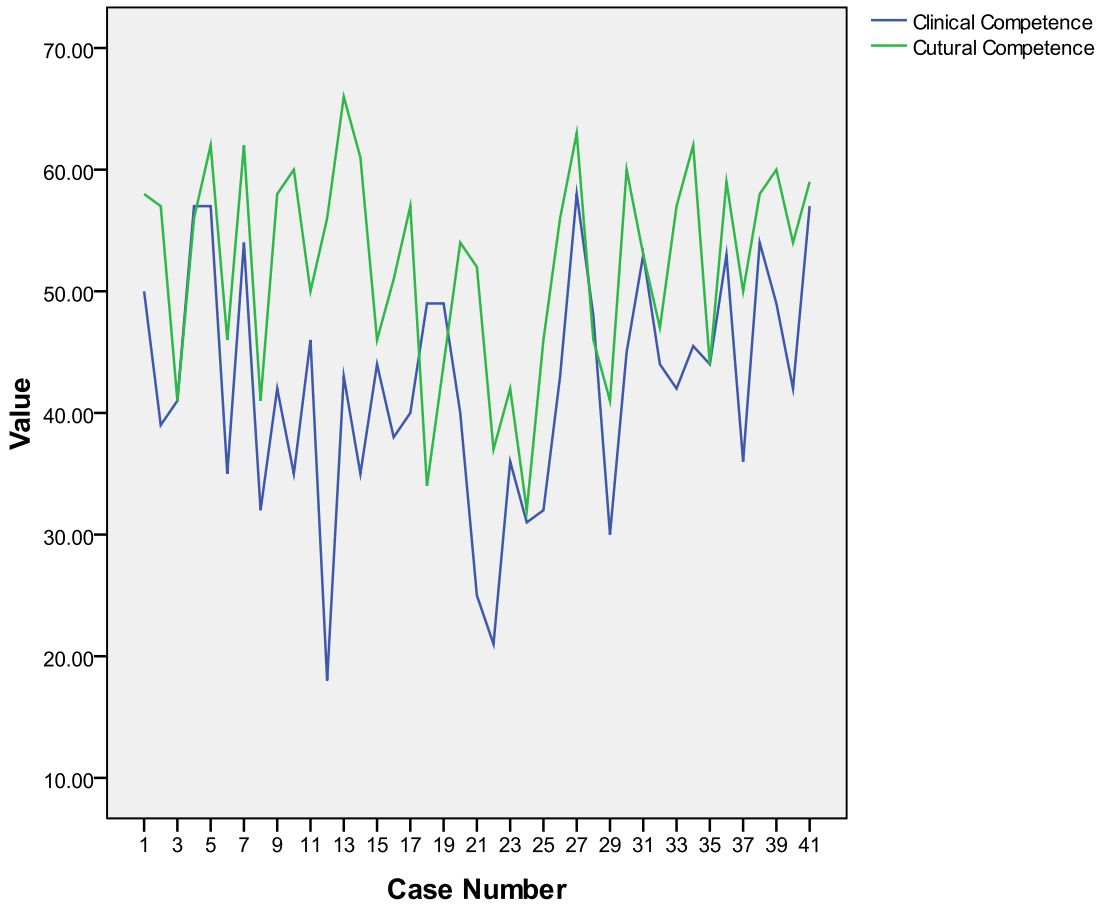
No.	Student	Clinical Competence	Cultural Competence	Difference
1.	10	18	56	38
2.	17	25	52	27
3.	12	35	61	26
4.	8	35	60	25
5.	11	43	66	23
6.	2	39	57	18
7.	15	40	57	17
8.	34	45.5	62	16.5
9.	18	21	37	16
10.	30	45	60	15
11.	33	42	57	15
12.	16	40	54	14
13.	21	32	46	14
14.	38	36	50	14
15.	22	43	56	13
16.	14	38	51	12
17.	41	42	54	12
18.	4	35	46	11
19.	24	30	41	11
20.	40	49	60	11
21.	6	32	41	9
22.	1	50	58	8
23.	5	54	62	8
24.	7	42	58	6
25.	19	36	42	6
26.	37	53	59	6
27.	3	57	62	5
28.	23	58	63	5
29.	9	46	50	4
30.	39	54	58	4
31.	32	44	47	3
32.	13	44	46	2
33.	35	57	59	2

34.	20	31	32	1
35.	29	41	41	0
36.	31	53	53	0
37.	36	44	44	0
38.	28	57	56	-1
39.	27	48	46	-2
40.	26	49	44	-5
41.	25	49	34	-15

For four students, their cultural competence score was lower than their self-rating of clinical competence and for a further three students, the self-ratings for these competences was the same. However, these were in the minority as the remaining 32 students rated their cultural competence higher than their clinical competence. Of this group, 19 had self-ratings of cultural competence which were at least 10 points higher than their self-rating of clinical competence.

The line graph in Fig 8 offer a comparison of the differences. Comparison across individual scores for clinical and cultural competence showed that a number of students ranked themselves very low on clinical competence but very high on cultural competence, for example student numbers 10, 12, 13, 14, 21 and 34. On the other hand only three students, numbers 4, 18 and 5, thought that they were more clinically competent than they were culturally.

Figure 8 Line graph of students' self-assessed clinical competence and cultural competence compared



A related t-test (see Appendix 17) was conducted on the overall scores using SPSS version 15.1 in order to see whether there was a significant difference between the students' rating of their clinical competence compared to their rating of their cultural competence. The results indicated a significant difference.

Results from a correlation using Spearman's Rank order also indicated that there was a significant ($p<0.003$) positive moderate correlation of 0.45 between the two variables (see Appendix 17). In other words, in general, if students deemed

themselves to be competent clinically, they were likely to see themselves also as culturally competent.

Summarising findings from the repertory grids

Data from the repertory grids were reviewed and examined for puzzling/unexpected aspects and to look for inconsistencies and contradictions. The procedure sought to ensure that valid inferences could be drawn and that it could be interpreted and understood by individuals who were outside the study.

There were occasional instances where there did not appear to be an immediate fit for the data and by adopting a process of constant comparison, the researcher had to arrive at decisions about them. The process of constant comparison involved comparing the adjectives and codes within and across the grids as new grids were brought into the process, categorising codes into categories which related to each other using a rule which described the category and which was a reflection of the codes within them. Integrating categories which evolved, looking for underlying uniformity and finally coming to conclusions and writing theory gathered from the coded data was challenging. Incorporation of some quantitative data allowed for the development of a fuller picture of the findings and as Weber (1990) suggests, the highest quality content-analytical studies use both quantitative and qualitative analysis of texts. Therefore, although analysis was in the main qualitative, the additional quantitative analysis offered another side of the story.

Key factors identified from this study were that

- Students' constructs of clinical and cultural competence were different;
- Students experienced greater difficulty in finding adjectives to describe cultural competence compared to finding adjectives to describe clinical competence;
- Students' self-assessed level of cultural competence was significantly higher than their clinical competence;
- Students who deemed themselves to be clinically competent tended also to deem themselves to be culturally competent.

Discussion

Data suggested that students would view an individual as clinically competent if they were approachable, a good communicator, confident, caring, professional, enthusiastic and had good interpersonal skills. If we assume that repertory grids represent constructs – a means by which individuals construe the world and their expressed understanding of it – then, we may conclude that this was the view of clinical competence by these undergraduates. This perspective on clinical competence is consistent with the literature (Cross and Hicks, 1997; Cross, 1995). The constructs also reflected general perceptions of competence where attributes of knowledge, skills and attitude are seen as fundamental (Stengelhofen, 1993) and these were evident in their descriptors. Physiotherapy students' familiarity with the topic would have been further increased from experience in clinical placements and their own reading. In contrast, availability of literature on the topic of cultural

competence was more limited and their experience of it within the workplace was unknown. Difficulties students experienced in completing the grids on cultural competence was not altogether surprising since as indicated earlier people tend to have more constructs around topics they know well (Kuipers and Grice, 2009). These factors offer explanation, in part, of why students found the task of finding adjectives to describe clinical competence much easier than in describing cultural competence.

Not only did the students struggle to find sufficient adjectives to construe the concept of cultural competence but the phrases which they employed were more subjective and more loosely defined than they were for clinical competence. Their constructs suggested that an individual who is culturally competent is someone who is open and accepting, caring, knowledgeable and experienced, recognises and understands individuality, believes in equality and is respectful. A significant proportion of the attributes of the culturally competent practitioner were prefixed with ‘not’, unlike clinical competence, where their constructs were written mainly as positive attributes. When these constructs are compared to the published works of writers such as Campinha-Bacote (2003) and Purnell and Paulanka (2008), identified links in the constructs of the students appear consistent in broad terms with the main themes which emerge. For example, these authors also cite developing appropriate knowledge, skills and attitudes, and the achievement of equal treatment for diverse groups. However, unlike perceptions of clinical competence where it was possible to make direct comparisons with the literature,

it was more difficult to make this direct link for cultural competence because perceptions of cultural competence appear to be less pervasive.

Findings from repertory grids suggest that students construe clinical competence and cultural competence in some similar but also very different ways; therefore, to assume that clinical competence is inclusive of cultural competence from a student perspective could be inaccurate. Although there were overlapping skills such as being experienced, knowledgeable and caring, there were clear differences in the need for openness, recognising individuality and addressing equality. It is interesting that openness and being accepting ranked as the highest factor in students' perspective of practitioners who are culturally competent. Perhaps these are clear indicators of areas to address in developing skills in undergraduate curricula.

Criticisms of repertory grids relate to their size in that how an individual construes aspects of the world may not be represented by pieces of information, in this case represented by 10 pieces of qualitative data and 70 pieces of quantitative data. Additionally, a criticism of repertory grids is that individualised specifications of quantitative elements and constructs within a grid can only offer summary measures although where constructs and elements are specified, direct comparisons of individual grids may be made.

Strauss and Corbin 1990) identify that research must take into account the interconnectedness of actions since the world does not occur in a vacuum.

Findings from repertory grids are considered in light of the other investigations within the study in Chapter eight.

6.6 Questionnaire T2 (QT2)

QT2 Administration

At the end of year two of the programme, the questionnaire which students had completed in year one, semester 2 was re-issued. This occurred nineteen months after its first issue and after students had completed a further 16 weeks of clinical placement. I decided on its re-issue partly to find out how students were getting on in relation to the topic and to pick up any concerns. I was also unsure whether I would be seeing the whole cohort together again as a group because of further placements. Staff visiting students including myself agreed to take the necessary envelopes containing a consent form and letter, the questionnaire and an addressed envelope (see Appendix 7). Students were requested to complete the forms and to return them via visiting lecturing staff. The response rate was very good and a comparison of findings between the first and second issues is compared below.

Findings from comparative analysis of T1/2

The response rate was 100 percent for QT1 and 91% for QT2. Forty-one out of the initial 45 students completed the Caring for MEGs Questionnaire at QT2. Individuals were not matched for their responses across the two questionnaires so results are presented as aggregates. Their responses showed that the year group,

age and gender remained similar to that at QT1 (see Table 13). Discrepancies arose from different numbers of students completing the questionnaire at QT1 and QT2 due to absence and/or failure to complete, and the omission of certain questions by individual students. Changes in age distribution result from the fact the QT2 was 19 months later.

Table 13 Age and Gender at QT1 and QT2

Age	QT1 (100%)	QT2 (91%
18-25	44	38
26-35	1	2
36-45		1

Gender	QT1	QT2
Male (%)	4	5
Female (%)	41	36

Given that there was a total of 49 enrolled students on the official register for the cohort, only a maximum of 45 students were ever involved in the investigations; therefore, the discrepancy in the rise in the number of male students from four to five could be explained by a change in the number attending when the questionnaires were completed.

Ethnicity (Q2.1, 2.2, 2.3)

Students maintained their preference to be categorised firstly by colour, followed by colour and nationality (see Table 14).

Table 14 Self-classification of ethnicity QT1 and QT2

Categorisation of own ethnicity	**QT1** n=45	**QT2** n=41
White	22	29
White British	9	8
White English	7	1
British	2	2
Other	5	1
Total	45	41

There was an increase in the number of students identifying themselves as 'White' compared to the categorisation of 'White English' or 'other'. Students were equally forthright at QT2 in their comments regarding the closed responses to ethnicity as at QT1 although fewer comments were made (n=12 at QT2 compared to n=20 at QT1). Comments at QT2 include:

> *If Irish is counted as ethnic group shouldn't English, Welsh Scottish French etc. be included? Makes me wonder if Irish should be classed as an ethnic group. It appears that this stereotypical definition is a little dated – does white tell us anything about the culture for example – white people can be Jewish as well as Irish.*
>
> *Someone could be Irish and white, Jewish and white, black and Irish etc. making the categories in 2.2 difficult.*
>
> *If Irish is a separate ethnicity is it Northern or Southern Irish – surely if they are white then this is their ethnic group. Otherwise I would describe myself as British rather than white – that could be French, German, American or any other nationality.*

Students had increased their professional activity amongst MEGs between QT1 and QT2 with more than 50 percent of the group spending over 30 percent or more of their time with these groups compared to over 80 percent spending less

than 10 percent at QT1. This was expected given the clinical experience which they had gained during the intervening period.

Students' ability in meeting the needs of patients from minority groups (Q2.5)

At QT2 there was still a significant difference between students' self-assessed ability to meet the needs of MEGs relative to the majority white population. The mean ratings at QT2 for ability to meet the needs of the majority population were 76.2cm compared to 52.9cm for MEGs. The level of significance at 0.001 at QT2 was the same as at QT1 but there was a reduction in the standard deviation from 19.7 to 16.4.

Common problems faced by students when dealing with issues related to caring for people from MEGs (Q2.6)

At both QT1 and QT2 around 80 percent of respondents provided a response to this question. Common problems faced by students caring for people from MEGs at QT2 were similar to those identified at QT1. Again, issues of language barriers (n=25) and understanding and communication (n=10) were most commonly mentioned. However, at QT2 some individuals were more specific in the difficulties encountered, mentioning, for example, differences in culture and attitudes. At QT1, 10 students expressed a lack of experience in caring for MEGs whereas only two students expressed little or no experience at QT2. None of the students at QT2 made the comment that they had no problems. Illustrative comments on common problems at QT2 include:

unsure whether they [MEGs] have understood what you have told them.

not wishing to offend patients.

differences in attitudes and expectations, unable to fully relate to their lifestyle or point of view.

understanding naming systems.

differing beliefs about who is responsible for patient care i.e. physio wants to increase patient activity but their culture believes they should sit at home and be cared for by the family.

Awareness of issues attributable to ethnic origin where colleagues have had particular problems (Q2.7)

At QT1 10 students said that they were aware of colleagues with problems that were attributable to ethnic origin. By QT2, responses decreased; eight and five issues were highlighted instead of the seven highlighted at QT1. While the problems identified at QT1 appeared to have been centred on school/college and experiences outside the undergraduate course, at QT2 these were directly related to the clinical setting: undressing (n=2), praying (n=2), food (n=2), beliefs (n=1) and death (n=1).

In addition, the two comments below were offered.

was unable to assess patient fully because she refused to remove her outer garments and a patient kneeling to pray during a religious period.

Patient's family member died and she couldn't come to the treatment for a couple of months as she was an Asian lady and needed to stay at home for cultural needs.

These comments demonstrated a more sophisticated and detailed appreciation of issues attributable to ethnic origin. Such comments were not in evidence in responses to this question at QT1.

Assisting minority groups to get the best from the Health Service (Q2.8)

Although the responses were fewer at QT2 (n=24) than at QT1 (n=41), they offered greater depth and breadth of understanding and were more widely considered. The examples and suggestions presented below from QT2 indicate that students had become more familiar with practical needs of working with MEGs. They were also able to identify the types of facilities that could be made available.

> *good communication e.g. translators if required. This must also include friends/relatives – they also have a right to understand what is going on. Provision for beliefs e.g. regarding food etc.*
>
> *understanding from those treating them, not being treated differently from other patients unless it is necessary for medical/religious/cultural reasons, the use of an interpreter if needed.*
>
> *interpreter translator service, provision for special dietary requirements, understanding by staff of culture e.g. women being unwilling to undress, Muslim ladies wishing to wear a hijab, patients family.*
>
> *having ethnic minority groups involved in committees, discharge planning, providing appropriate interpreters.*
>
> *staff who understand and have knowledge about their cultures and beliefs. Interpreters and people who are apt at communicating despite language barriers*

A summary of possible solutions which were offered to assist MEGs getting the best out of the NHS were interpreters (n=9), understanding staff (n=6) and information booklets (n=4).

Barriers for patients from different minority backgrounds in receiving the best from the NHS (Q2.9)

This question explored possible barriers in health care. There were 25 responses to this question at QT2 compared to 45 at QT1. Although again there were fewer responses, the content was lengthier. The main themes were similar in both questionnaires and related to 'lack of understanding and knowledge'. However, language was identified as a significant factor at QT2, whereas at QT1 it was 'cultural issues'. At QT2, as expressed in the quotes below, students indicated a greater degree of empathy in addressing the needs of clients including expressions of antagonism towards the attitude of staff who appeared less caring. Students cited lack of respect, racism and poor communication as additional factors. A summary of comparable responses is offered in Table 15.

Table 15 Summary of barriers to MEGs receiving the best out of the NHS identified at QT1 and QT2

QT1	QT2
beliefs and cultural issues (n=24)	language (n=13)
lack/poor understanding and communication (n=14)	lack of understanding (n=9)
lack of knowledge (n=7)	lack of knowledge (n=4)
lack of respect (n=5)	low awareness of staff (n=3)

Illustrative comments include:

poor communication, inflexibility on the part of both staff and patients

language barriers, barriers created by lack of understanding by either patient or professional about each other's different backgrounds regarding religion culture, family styles etc.

ignorance of different ethnic backgrounds or unwillingness to learn about them. Also people who do not want to give the extra time to make these patients feel more comfortable

language difficulties, cultural barriers e.g. undressing, personal space and touching etc., professionals who do not attempt to understand patients or take the time to fully assess patients due to language

lack of understanding of people's attitudes and beliefs towards pain and illness

Satisfaction with the education systems within the university and clinical settings (Q2.10Section A and B)

At QT2, there was evident dissatisfaction with the education systems in both the academic and clinical settings, but this appeared to be greater within the latter (see Table 16). At QT1, 53 percent of students stated that language had not been addressed in the educational setting and only 46 percent were satisfied. There was much greater satisfaction with the systems for religion and culture. At that time, in respect to clinical settings, students had little or no clinical experience on which they could base their response, therefore percentage satisfaction was not given. However, at QT2, 80 percent of students now expressed satisfaction with language in the educational setting compared to 53 percent in the table. Nearly 32 percent of the students thought language had not been addressed in the clinical setting, or were dissatisfied.

Table 16 Percentage satisfaction of students regarding education systems

Questionnaires	**QT1**	**QT2**	**QT1**	**QT2**
Settings	*Educational*	*Educational*	*Clinical*	*Clinical*
Language	46	80	-	53
Religion	96	83	-	63
Culture	96	87	-	63

At QT2, 83 percent of the students were satisfied to some degree with the extent to which religion was addressed within the educational context compared to 63 percent within the clinical setting. At QT2 the remaining 37 percent expressed some dissatisfaction or thought the subject had not been addressed.

Approximately 87 percent of the students expressed some degree of satisfaction with the education in culture within the academic setting compared to 63 percent in the clinical setting. Thirty three percent were dissatisfied or thought that the subject had not been addressed within the latter. There was a slight drop in the satisfaction rating within the educational setting between religion and culture from QT1 to QT2. For instance, two students at QT1 expressed dissatisfaction with 'culture' as it was addressed within the academic setting and this had risen to four by QT2.

Number of lectures attended (Q2.11)

The response to the question on the number of lectures attended had increased significantly since the administration of the questionnaire at QT1. This was expected given the intervention of the module and the students' clinical experience.

Table 17 Comparison of number of lectures attended: QT1 and QT2

Number of lectures attended	QT1	QT2
None	2	no response
1-5	42	13
6-10	no response	20
11-15	no response	7
Total	44	40

At QT2, 24 students felt able to list the topics covered in the lectures. Topics identified were cultural sensitivity (n=12), visits and discussion of visits (n=12), different religions (n=3), outside speaker (n=3) and language (n=3). Again, there was an overlap in some of the responses. Other topics identified were ethnicity (n=2), minority groups and translators. In comparison to responses at QT1, the content of the lectures within the IBR and Clinical Studies modules were clearly identified in the responses at QT2. Responses in QT1 appeared to have been based on students' introduction to a lecture on religion and a brief introduction to studying cultures in a previous module.

All the respondents (n=41) at QT2 thought that the lectures were 'useful' or 'very useful'. The results were similar to those collected at QT1. The main difference was that at QT1, two students thought that the lectures were 'not at all useful' whereas, all the responses in QT2 were positive. At QT2, 28 students made comment about the lectures. Thirteen thought the lectures were useful, five felt that they needed to relate more to practice, four indicated that they had increased their awareness. Four students identified that the visits had been worthwhile and three stated that the lectures were interesting. The comment that the lectures

consumed too much time was made by three students while two admitted that they ‘could not remember'. There were other comments made by individual students: disagreed with content, too short, too much volume, unhelpful (n=2) and few cultures mentioned. These later comments appear to be inconsistent with the response to the usefulness of the lectures.

Suggested training (Q2.12)

The overwhelming suggestion made by fifteen students at QT2 was for greater contact, discussion and an invitation to work with MEGs. Eight students suggested greater training. Two suggestions included an increase in the number of visits and handouts.

Level of awareness of cultural groups (Q2.13)

It is not known how many of the students had come into contact with MEGs during their clinical placements but there was a general increase in the level of awareness. Table 18 reports the means for the group at QT1 and QT2.

Table 18 Level of awareness of cultural groups

Groups	**Mean (n)**	**Mean (n)**
	QT1	QT2
African	2.8 (45)	3.2 (41)
Caribbean	2.5 (45)	3.2 (41)
Bangladeshi	2.0 (45)	3.2 (41)
Indian	3.7 (45)	4.3 (41)
Pakistani	3.3 (45)	4.3 (41)
Chinese	3.3 (45)	3.1 (41)
Jews	4.2 (45)	4.3 (41)
Irish	5.3 (44)	4.8 (39)
Other	8.5 (1)	7.2 (2)

Except for the Chinese and the Irish, all the mean scores had increased from QT1 to QT2. The most notable increases in levels of awareness were associated with the Caribbean, Bangladeshi, Indian and Pakistani communities. Only one student gave a score in the 'other' category in QT1 for Japanese compared to 2 students in QT2, who had specified one as Muslim with the other left unspecified.

Awareness of disease prevalence/incidence/mortality between different ethnic groups (Q2.14)

The responses to these questions at QT1 and QT2 are presented in Table 19.

Table 19 Awareness of disease prevalence, incidence and mortality: QT1 and QT2

	Prevalence		**Incidence**		**Mortality**		**Total scores**	
QT1 (n=45) QT2 (n=39)	QT1	QT2	QT1	QT2	QT1	QT2	QT1	QT2
No	9	12	10	9	15	13	34	34
Not Sure	15	15	14	21	19	21	48	57
Yes	21	12	20	9	10	5	51	26
Missing	0	0	1	0	1	0	1	0
Total	45	39	45	39	45	39	134	127

Generally, students appeared to become *less* sure of any differences i.e. the 'yes' answers were reduced by almost half and there was an increase in the 'not sure' category, but more were of the opinion that there were no differences.

As at QT1 the predominant comment made by eight students was regarding sickle cell diseases while other individual comments were made regarding different pain thresholds, diabetes and strokes in Asians, but opinions were mixed.

Awareness of the availability of specific educational resources (Q2.15)

Thirty-eight students answered the question but only seven were aware of specific educational resources available to help staff in their cultural practices in clinical areas and only five were able to say what these were. These consisted of training in a language, a basic language course, leaflets, a cultural awareness guide, videos and outside speakers. At QT1, none of the students were aware of any resources.

General comments (Q2.16)

At QT2, two general comments were made and are presented below. This contrasts with six comments made at QT1.

> *It is very important to be aware and informed about cultures/minority ethnic groups but it is also a two-way process and sometimes people from these groups can be reluctant to accept our culture. Generally I think if both sides are prepared to accept and consider the other and work together, difficulties and differences in culture should not be a problem and can be overcome. Language barriers are understandably difficult. Otherwise I think that it is important for people to be aware of each other differences and their culture and accept them.*
>
> *It is important that as Britain is becoming more and a more multicultural society physiotherapists and other health professionals need to be prepared in language, culture, religion and lifestyle of the various groups.*

Although fewer comments in total at QT2, again it can be seen that the depth of these remarks was deeper than any contained in the questionnaire at QT1.

Discussion

The ‘Caring for people from MEGs’ questionnaire was a valuable exploratory tool, providing useful background data on students, and their self-perception on the topic of caring for minority ethnic groups. It provided a mixture of qualitative and quantitative data which assisted in formulating an overall view of the cohort.

The biographical information gained was in keeping with the recorded statistics of the traditional intake of students in undergraduate physiotherapy courses in the UK. The group were generally young, white, female and from middle class backgrounds, as has been the case historically in physiotherapy (Mason and Sparkes, 2002). It was obvious that this 'traditional' group of students did not reflect the profile of the service users with whom they generally engaged while working on placements within the inner city. Hunter and Krantz (2010) argue that perception is influenced by the background and characteristics of an individual and that these are highly influential in student engagement with learning and teaching. Cultural self-assessment, including ethnicity, is said to be one of the important factors which should be considered when developing programmes which address cultural competence (Campinha-Bacote, 2003; Sasnett et al, 2010).

Students were given the opportunity to present their own ethnicity by drawing on their preferred adjectives. The majority chose to describe themselves as ‘white’, with significant numbers adding ‘English’ or ‘British’. How this sense of identity impacts on individual constructs was not explored but ethnicity is considered to form the core of an individual’s identity and is thought to convey characteristics

individuals may wish to present in particular contexts (Peach, 1996). There are continuing discussions on how to define ethnicity but its description as a complex social construct that influences personal identity and one which 'groups social relations' (Ford, 2010) suggests that it is difficult to divorce influences of ethnicity from personal constructs. It is not known whether a more heterogeneous group of students would have responded in similar ways to the questions which were posed. Issues arising out of the homogeneity of groups in teaching cultural competence has been recognised; Romanello and Holtgreve (2009) suggest that where multicultural characteristics do not obviously exist in the student body and faculty environment, interventions may need to be employed which offer opportunities to challenge student beliefs and development in this area. However, assumptions regarding the perception of cultural competence of these students based solely on their stated ethnicity would be misleading.

The fact that the majority of the students preferred to self-classify their ethnicity rather than to use compulsory tick boxes may also be evidence of how strongly self-assessment could influence perception. Indeed, many resented the compulsory tick boxes, especially since they were viewed as confusing colour and geography with religion. The study highlighted two important areas which the author considers to be an important aspect in the learning and teaching of the topic. These are the relationship of ethnicity to identity and the purpose and function of ethnic classification, especially in light of the fact that collection of this kind of data can appear intrusive. Kelleher and Hillier (1996) are of the view that the relationship between ethnicity and self-identity is inextricably bound. Nationally

and internationally, the collection and classification of ethnic data continues to pose its own challenges. However, in the learning and teaching of cultural competence, it is suggested that attention should focus on approaches which assist in deepening understanding of the characteristics of identified populations, and that the emphasis of the exercise should not be on the gleaning of data but on outcomes which might be achieved in using it.

Many undergraduate physiotherapists will spend much of their clinical experience and/or their educational experience within the inner city areas of Great Britain and this group was no exception. In the initial questionnaire issued at QT1 in the first year of the programme, the majority of the students indicated that only between 0 and 10 percent of their professional activity was spent with MEGs. When the questionnaire was administered 16 months later at QT2, after further clinical experience, this had risen to 50 percent spending between at least 0 and 10 percent and 20 percent spending over 50 percent of their time with these groups. The exposure of undergraduate physiotherapists to different minority groups during their undergraduate programme is likely to be high. Genao et al (2009) identifies the potential for cultural and ethnic discordance between health care providers and service users and that the need for cultural competence training is becoming a vital component of medical education. The case for developing cultural competency programmes in physiotherapy appears to be no less acute; therefore, exploring perceptions held by undergraduates on the topic assumes an increasing level of importance. To this end, the questions posed within the

questionnaire regarding practice and student abilities in this area were thought to be worthy of this exploration.

The use of the t-test gave an indication of how able students felt they were in meeting the needs of MEGs compared to the majority white population. Albeit a relatively crude test, it was nonetheless revealing in the data obtained. At both QT1 and QT2, students felt that they were less able to meet the needs of MEGs than they were in meeting the needs of the majority white population. If the results of the questionnaire are a reflection of undergraduate physiotherapists' opinion and perception of their ability, then developers of curricula will need to consider how best to enable them to close this gap. Interestingly, students were also able to identify this lack of ability in some of the clinicians who supervised them (see responses to QT2 2.9). If, by their own self-assessment, health care givers feel that they are unable to meet the needs of MEGs compared to the majority white population then implications for the quality of care MEGs might expect to receive is a cause for concern.

The questionnaire used the term cultural sensitivity as opposed to the term cultural competence from the literature; little differentiation is sometimes made between the two concepts (Okougha and Tilki, 2010; Whaley, 2008). However, the term cultural sensitivity was adopted by way of introduction to the study because it was a term with which the students were more familiar and was the term which was adopted within the curriculum. The topic of cultural sensitivity is also said to encompass notions of cultural awareness (Hutnik and Gregory, 2008). It was

assumed that a practical relationship exists between awareness and competence and that in order to develop cultural competence, one has first to become culturally aware (Campinha-Bacote, 2007). For the purposes of exploring the topic at the start of the study, this association was exploited.

Students identified their lack of awareness, and limited exposure and interactions with minority groups but they appeared eager to have this rectified. Students appeared to have difficulties in coming to conclusions regarding the significance of prevalence, incidence and mortality regarding diseases affecting different cultural groups. It has been suggested that a lack of accurate epidemiological data of particular groups means that health care professionals may be unable to get a true picture of the issues and that this could have a negative impact in health care of minority ethnic groups. Consideration of how ethnic data collection can be improved is already an existing cause for concern and increasing the familiarity of students with this and other epidemiological data could make an important contribution in equipping students to make reasoned decisions regarding health care of particular groups of people.

Following increased exposure and interaction with minority groups, students became more aware of their own learning needs but identified that there were limited resources available to assist them. Many of them relied on their clinical educators who, as has already been noted, may too have deficits in their own skills of cultural competency. It is clear that although there have been strides in developing resources for the learning and teaching of cultural competency, there is

still a major deficit in their availability to support the learning and teaching of cultural competence to undergraduates within the UK. Developing programmes such as the London Deanery website identifies some useful material and offers useful links, but like other websites, the range of material found within the UK appropriate to learning and teaching in undergraduate heath care education is limited. Additionally, there is limited guidance on how educators and students might make best use of the limited materials which are available.

An additional area of concern which is not often expressed in the literature is the increasing support students may need as they become aware of their limited ability to deliver equity of care to different minority groups. Increased interaction and exposure to different cultural practices can lead to a lowering of confidence and hopelessness if relevant and sufficient resources are not in place to support the learning and teaching experience.

Summary

This questionnaire which was distributed in year one and again at the end of year two of the programme identified a number of issues for this group of undergraduate students. They included concerns over reasons for ethnic data collection and self-classification of ethnicity, limited ability to care for MEGs compared to caring for the majority population, limited availability of appropriate learning and teaching resources to assist learning and teaching of cultural competence, and limited reciprocal learning opportunities to develop cultural competence in association with relevant communities. Changes in the data could

be identified across this time in that they had significantly increased exposure to minority groups; they found lectures and sessions had been useful; rather than none, limited resources from practice could be identified and they become increasingly unsure about prevalence, incidence and mortality in relation to MEGs. However, several factors remained similar or unchanged. They continued to express concerns over ethnic classification and their ability in meeting the needs of MEGs; in addition, finding appropriate support and resources remained challenging.

6.7 Reflections on the second year of the study

Several aspects of the investigations in the second year of the case study were made personal to the students in the hope that it would trigger greater reflection in becoming more culturally competent in their approach to practice. At the time, when I was undertaking the investigations, although this was a considered ploy, an overview suggested to me that this may have been achieved to a certain extent. Addressing their concerns from year one and giving opportunity for individuals to personally identify areas for development, I felt helped to make their learning more meaningful. However, I recognised from the feedback that perhaps too much time may have been given to a topic which I was more passionate about than they were.

I decided to use repertory grids because they offered a way of approaching the problem by getting into students' heads to find out how they perceived cultural competence. The approach of starting with a blank grid and using open coding of

the data of the two competencies, creating new codes and categories offered a way of gaining insight of students perceptions of them. I became more excited about using grids in this study following discussion with a colleague who had used them previously. At the time, I gave little thought to being a novice user of the grids, a situation I had to address fairly quickly once I had made the decision to use them. Fortunately, I had previously been a guinea pig in a project so I had gained a degree of familiarity with using them practically and with some of the issues which could arise. Computerised packages for the analysis of repertory grids is an increasing area of growth and developments in this area escalated during the time of the project. Unfortunately, although I recognised the untapped potential of exploring my data further through these developments, I did not have the time to pursue further training to develop the requisite skills. Despite my efforts, I could find no one locally who felt they could assist. Nonetheless, armed with assistance to pursue grounded theory, I decided to focus on analysing the data using this approach, making a conscious effort to set aside preconceived ideas and to allow the data to generate theory.

I also came to realise that computer packages such as NVivo could have been helpful in managing qualitative data but again this needed time set aside to learn and develop a new skill. I decided that my preference was to get down to manually coding the data and that meaningful results could also be gained in this way.

In reflecting on my introduction of repertory grids into the undergraduate curriculum, I recognise that this would not have happened without the impetus of

this study. However, like me, I hoped that the students would find value in completing them as I felt that it offered scope to look at the qualities of practitioners which they might aspire to rather than just an approach to research. I also felt that it cut to the core of their understanding, or lack of it, regarding their perceptions of cultural and clinical competence at that point in the programme. I did wonder whether offering a definition of cultural competence was the right decision. However, based on the questions which they were asking in the session, I felt that they were struggling in understanding the concept and that the offer of a simple definition would help them to understand and move forward in completing the grids more efficiently than would otherwise have been the case. Researcher interpretation of data will continue to be an important factor in qualitative data analysis and I am comfortable in the knowledge that this is the case but I also recognise that it is a skill which requires on-going development.

The students left the university setting after the Easter break to pursue work in their clinical placements for the remainder of the academic year and so I had minimal contact with the group as a whole until the start of the third year of the programme. Although I had opportunity to visit individual students during this time these visits were mainly aimed at discussion of their learning contracts, issues in learning and teaching which may have arisen between staff and students and other transitional factors. As an educational visitor, I used some of this time to ensure students were accomplishing and fulfilling the learning outcomes for their clinical work.

Requesting students to complete the questionnaire T2 while they were away from the University, I felt, helped to remind them of the relevance of the topic. However, I was also aware that they may not have welcomed the additional task, especially while learning in new and challenging environments. In addition, administering distribution and collection placed reliance on other staff and meant that the return rate could have been poor. Fortunately, the majority of staff and students were obliging and responses in the questionnaire appeared to have been completed with care.

My role as a lecturer continued with the other year groups and thoughts of how I might manage the learning and teaching of cultural competence with prospective students in the new academic year. I also used some of this time to reflect on some of the data that I had gathered and to contemplate how, in light of the findings to date, I was going to take the study forward.

CHAPTER 7 CASE STUDY – YEAR THREE

My association with the cohort in year three was much less than in the two previous years. I continued to maintain close contact with my own personal and dissertation tutees within the year group but data collection was limited to an end of programme questionnaire to the interview group from year two. Restriction on data collection was mainly due to students undergoing placements in widely spread locations for the majority of the year (see Appendix 4). I hoped that the end of programme questionnaire would help to capture some of their relevant experiences over the year.

7.1 End of programme questionnaire

Purpose and justification

At the end of the third and final year of the BSc (Hons) Physiotherapy undergraduate programme, contact was made with the nine students who had formed the initial interview group. Students had returned to the University and were in a classroom completing end of course evaluations. My aim at this juncture was to thank the group for their participation in the research and to offer them the opportunity to leave their contact details should they wish to be informed of the outcomes. However, I also thought it was an opportune time to try to conduct a final exploration of their views on the topic of cultural competence as they had experienced it on the programme. The idea was to try to gain their thoughts on issues which had been discussed in the initial interview in year one, issues raised

in the questionnaires QT1 and QT2 and for them to offer a general overview of their experience. I was contemplating how these issues might have changed and how they might present now they were on the verge of graduating with the potential to become State Registered and Chartered Physiotherapists.

Administration

I made a request to see the group before they embarked on completing formal evaluations for the programme. I perceived that they were in good spirits as they were nearing the completion of three years of study and proceeded to tentatively ask whether they might consider completing a final questionnaire for me. Since this was an additional evaluation form, I made a formal verbal request to the group. To my surprise, they greeted the request to offer feedback with greater enthusiasm than anticipated and offered to complete the questionnaire along with all the other forms they were required to complete.

The questions asked were an amended version of the Group Interview Form (see Table 4) and consisted of the questions identified in Table 20 – the end of year questionnaire, entitled ‘Cultural Competence’. They were requested to complete the forms anonymously and independently. All nine students submitted the completed questionnaire and left them in an envelope on a table with other completed evaluations as requested. Thematic analysis was conducted on the data to identify the main themes or contextual units i.e. the largest element in the response which could fall under an identified category (Flick, 2009).

Table 20 Content of end of course questionnaire

Cultural Competence
1. What skills do you think a physiotherapist requires to be culturally competent? 2. Do you think you have these skills? 3. Which of these skills would you like to develop further? 4. Now that you are nearing the completion of your undergraduate course, what recommendations would you make regarding the development of cultural competence in physiotherapy undergraduates with a) the University and b) the clinical environment? 5. Please give an indication of any training programmes, videos etc. you received during the course of your clinical work. 6. Any further comments in relation to this topic would be greatly appreciated.

In their responses to question one regarding skills required to be culturally competent, the majority (n=8) of students identified in some way the need for increased awareness of different cultures and religions.

For example:

> *Student 1 Awareness of different cultures and religious beliefs of the population and the implications of these beliefs on physiotherapy treatment. The need to be patient and willing to learn and listen from the patient.*
>
> *Student 2 Open minded and accepting of all beliefs, non-judgemental. Background knowledge in the major religions/cultures of their client group. Excellent communication skills and listening skills including non-verbal communication. Ability to instil trust and sense of confidence in patients*

In response to question two, two students was forthright in saying ‘yes’ and ‘Definitely communication and sensitivity has been developed through the course’. The remainder were more cautious in expressing whether they thought they had acquired the skills of cultural competence. Statements from the two students below epitomised their broad feelings.

Student 4
I feel I have a certain degree of these skills, but as with many skills, I believe that these skills can only develop through experience

Student 8
I hope I have awareness and sensitivity but I don't think all situations can be planned for. I feel I have had a broad range of experiences with people of different cultures during the course which have prepared me for the future.

Responses to question three were varied in respect of the skills the students said they would like to develop further. Three students indicated improving their communication while a further five highlighted increased knowledge and understanding of different cultures, beliefs and customs. The remaining student wanted to improve skills in asking people about their beliefs without feeling uncomfortable.

Recommendations which students made for the development of cultural competence within academic and clinical environments in the undergraduate programme were varied. In relation to the university environment, implications for treating people from different cultures, cultural visits, teaching about pain, inviting patients and increasing the diversity of the student intake were individually recommended. Two students thought that the experience was sufficient as it stood. Within the clinical field, four of the nine students identified using interpreters as an area to be addressed. The remainder wanted to see staff being encouraged to share their experiences of different cultures, increased awareness of educators in assigning patients from different cultures in order to increase the student experience and for staff to be encouraged to actively address ethnicity rather than

ignoring it for fear of appearing discriminatory. Examples of responses to question four are given below

Student 8

The University
A more culturally diverse student intake – although I think this is being addressed. I don't think that the taught part of the course could have been improved, but there is nothing like being part of a clinically culturally diverse population for learning sensitivity.

The clinical environment
I felt that clinicians try to be non-discriminatory with patients which means that their ethnicity/culture is not mentioned…….

Student 6

The University
I felt that the training we had was sufficient in terms of widening the knowledge base…

The clinical environment
Encourage staff members from different cultures to allow knowledge and experience to be shared

Seven out of the nine students said they had received no training, videos or used any other resources during their clinical work. Two had individually seen a video and heard a lecture on interpreters. Two had also undertaken a sign language course but it was not clear when these had been done.

Five students chose to make a final comment. These all included some aspect of 'difficulty' associated with teaching the topic and its translation into practice. Three examples are given below.

Student 4
It is easy to appreciate that cultural competence is difficult to teach! But it is interesting!'

Student 5
Difficult to teach in school and needs to be dealt with more in the clinical setting.

Student 7
I think on the whole the topic was covered well in university but unfortunately I was not able to follow this up in the clinical environment.

7.2 Discussion

The group of students chosen to complete this exercise were the students who in year one of the course had worked with minority groups with limited experience and had volunteered to be interviewed. Therefore, their enthusiasm for the topic of the study and to offer feedback has to be considered. It is not known how other students who did not volunteer for the exercise and who also had limited experience of working with minority groups would have responded.

Views of clinicians and other staff involved with the programme were not sought for this end of programme review, and the views given here are representative of the experiences of nine undergraduate students. Further criticisms of this study and the research in general are identified in Chapter nine.

Insight and comments offered in the feedback in this final part of the undergraduate course indicated that students had greater familiarity with the topic of cultural competence than when they were first interviewed. The expression of this familiarity was evident in the depth and breadth of the comments made and

appeared to be consistent with their educational attainment at level QT1A Level H of an honours degree programme. The students were able to identify elements of cultural competence which appeared to be beyond their cognition displayed in the first year of the course. For example, one student identified the 'increased knowledge of ethical and cultural issues, understanding religions and different responsibilities placed on people and how this affects [your] practice' and showed a greater level of critical self-awareness than was evident earlier in the data. Insight into this level of cultural competence is consistent with those expressed by writers such as O'Shaughnessy and Tilki (2007) and developments in the APTA (2008). Students were generally positive in their comments about how the topic of culturally competence had been managed within the programme but realised that 'these skills [could] only [be] develop[ed] through experience'. The dearth of resources to assist them identified in year one of the programme still appeared to be an issue. The contribution of these findings to the overall study has been analysed in the triangulation of the data in Chapter eight.

Different individuals will use different criteria to assess cultural competence (Kumas-Tan et al, 2007). The validity and reliability of the criteria for judging the cultural competence in undergraduate physiotherapists and undergraduate physiotherapy programmes within the UK remain unconfirmed. However, this short investigation identified that for this group of students, interaction with individuals from different cultures both inside and outside the classroom were vital components in developing their cultural sensitivity and awareness and consequently, I might suggest their cultural competence.

CHAPTER 8 EVALUATION OF THE DATA

This chapter addresses formal assessment within the undergraduate programme and the overall learning and teaching of cultural competence and uses triangulation as a means of interpreting and making sense of the data.

8.1 Formal assessments within the programme

Table 1 on page 113 shows the types of data and time frame in which it was captured. However, it must be recognised that this data were but a minor part of the total learning and teaching experience which occurred within the undergraduate programme. Learning outcomes for the formal learning and teaching of cultural sensitivity was focused within the IBR and Clinical Studies module i.e. first and second year modules respectively and the assessments within these two modules were the main forms of capturing students' learning of the topic. Attempts to assimilate and evaluate its learning and teaching in other parts of the programme was difficult. Students were successful in the achievement of the outcomes in both these modules indicated by the fact that all students passed the designated module assignments. The extent to which this was a measure of their cultural sensitivity and competence is open to debate.

The learning outcome for the IBR module was assessed by a 1000-1500 word critical incident analysis and a 1000-1500 word research assignment. The critical incident assignment required students to choose one critical incident from their

experience in Clinical 1, their first clinical placement. I was one of the markers on the team, and an overview of the submissions identified that two students made reference to ‘cultural’ issues and were related to the challenges of working with individuals whose first language was not English as a part of the incident. The research assignment required critical appraisal of published material which had been identified by the module team and was of less relevance in the context of these discussions.

Assessment of the Clinical Studies module required students to present a learning contract negotiated within a clinical module accompanied by an experiential learning analysis of 1000-1500 words. The contracts were developed in discussion with clinical educators and students were encouraged to build on learning experiences from previous placements and to use the contract to negotiate further learning through the placement. An overview of these experiential learning analyses showed that in the main, analyses were focused on experiences where assessment, communication, record keeping, confidence and clinical reasoning were the main issues. Therefore, evaluation of the learning, teaching and assessment of cultural competence within the programme was captured mainly through analysis of the data identified in Table 1.

8.2 Triangulation

Background

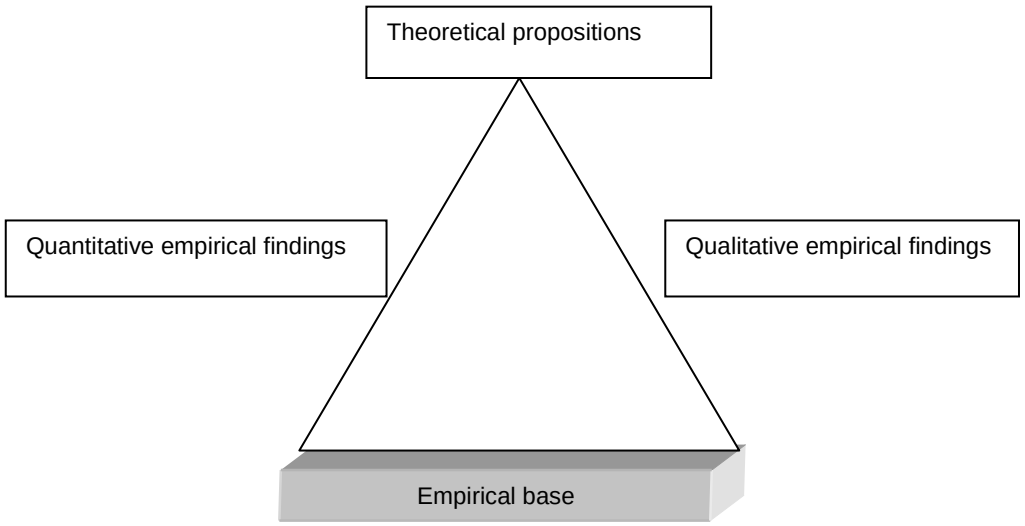
Decisions on how to triangulate the data within this study were based on the works of Ostlund et al (2011), Onwuegbuzie and Leech (2005), Bryman (2004) and

Denzin (1989). Triangulation is applied in a number of contexts and in different ways. In this study, methodological triangulation was adopted and was informed by the methodological metaphor approach suggested by Erzberger and Kelle (2003). Methodological triangulation uses a number of research methods in order to investigate one problem. It is unlike other forms of triangulation such as data triangulation (where data is collected through different samples at different times), theory triangulation (where multiple perspectives are used to assist in interpreting a single data set) and investigator triangulation (where more than one investigator investigates the same question) (Denzin, 1989*)*.

The model described by Erzberger and Kelle (2003) combines different data to facilitate clear identification of the links between different levels of epistemology, theory and methodology. Its representation is depicted in Figure 9. It is suggested that in mixed methods research, the weighting and priority given to the methods, the importance and the relevance of findings in analysing approaches can often remain obscure. This approach calls for the identification of the theoretical proposition/s represented; these are represented at the apex of the triangle. The sides of the triangle represent the relationship of findings from the analysis (quantitative and/or qualitative), while the base represents the empirical level within the study. This framework, as used by Erzberger and Kelle (2003) was originally published in Tashakkori and Teddlie's (2003) seminal work, the handbook for 'Mixed methods in Social and Behavioural Research'. The framework offers a means by which a description of the relationship between data

sets and theoretical concepts are set out and integrated at the stage of interpretation.

Figure 9 Triangulation Triangle (Adapted from Erzberger and Kelle, 2003)



In articulating the theoretical stance of the study and to validate discussions in triangulating the data, two propositions were forwarded. Proposition 1 was that the exploration of students' perception of cultural competence had clear implications for the teaching and learning of the topic. Proposition 2 deduced from the data, was that based on Proposition 1, a programme for supporting learning and teaching cultural competence could be developed. The underlying assumptions were that students' perception of cultural competence in undergraduate physiotherapy education is unknown and that cultural competence can be developed through teaching it within the curriculum.

The triangulation metaphor also offered a means of considering whether the data in this study were converging, complementary or diverging. Findings may be convergent (qualitative and quantitative findings leading to the same conclusion), complementary (findings harmonise each other), or divergent and contradictory (findings are at odds with each other). The triangle was used as an explicit way of linking theoretical propositions to empirical findings.

In Denzin's well-known works, mixed method triangulation refers to the adoption of two or more research methods in a study. The two methods are often cited as being an 'across method' or a 'within method' design (Denzin, 1989). An 'across method' design uses qualitative and quantitative methods of data collection in one study whilst a 'within method' approach uses one design to measure the same variables (Kimchi et al, 1991; Boyd, 2000). This study utilised both qualitative and quantitative methods; therefore, triangulation was consistent with an 'across method' approach. Ostlund et al's (2003) view of triangulation is also similar in some ways to the across method approach in mixed methods designs or methodological triangulation forwarded by Denzin (1989) and Casey and Murphy (2009).

Types of data triangulation may also include sequential and simultaneous methods (Creswell and Plano Clark, 2007; Flick, 2009). These refer to the chronological order in which data were collected. When qualitative and quantitative methods are adopted in sequence and the findings are complementary, this is referred to as sequential triangulation. Where methods are adopted simultaneously and findings

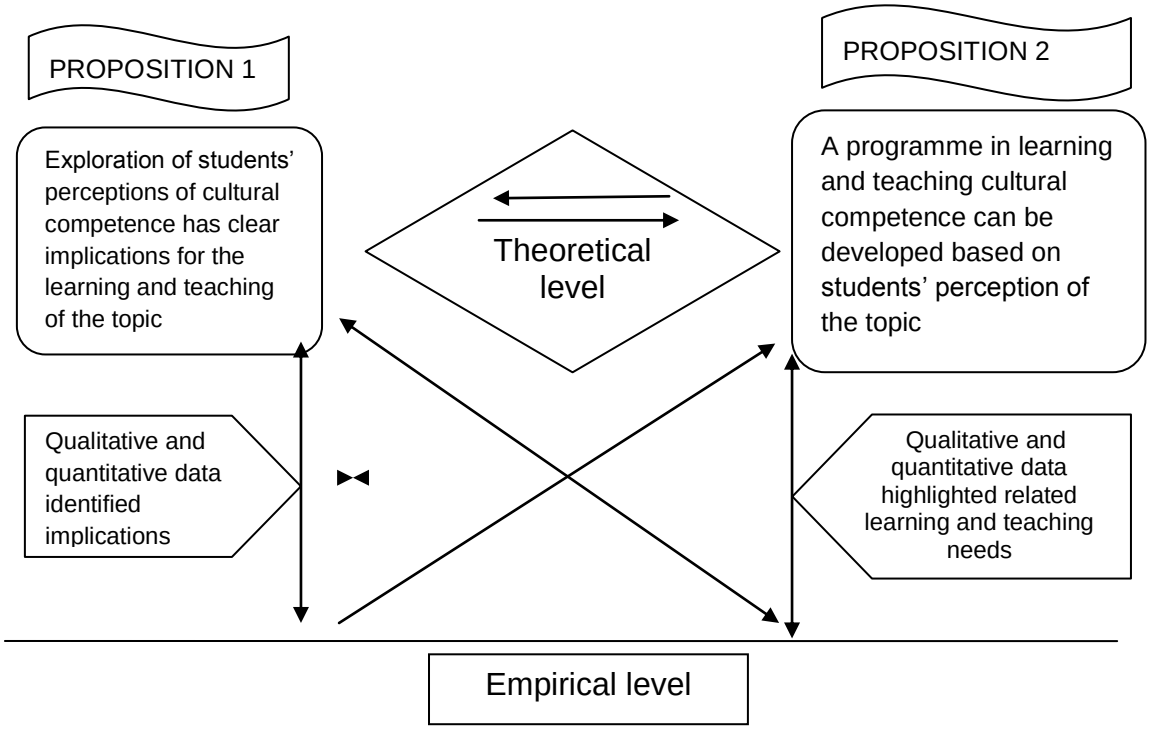
are complementary, this is known as simultaneous triangulation. Since qualitative and quantitative data within this study were not collected simultaneously, rather collected over time, triangulation was sequential. It is also worth noting that the notion of space triangulation recognises that scholarly works are culture bound and therefore may not apply to any society, anytime and anywhere and these are points of consideration which underlie discussions. A rationale for combining mixed methods within the study is offered in Chapter three. Sequential triangulation of the data also helped to overcome some of the practical constraints of research, for example collecting data whist continuing with the task of teaching, and enabled the development of professional activity whilst at the same time engaging in enquiry.

Triangulating the data

The sample was formed by the annual intake of students for the year. The main areas of data collection forming the empirical base of the study are shown in Figure 10 and types of data collected are given in Table 3.

Figure 10 Triangulation in the study

Adapted from Erzberger and Kelle's (2003) approach to triangulation (where results are complementary)



At an empirical level, comprehensive detail of the individual investigations may be found in the relevant sections of this thesis but a brief outline of them is given here for purposes of demonstrating how triangulation was achieved.

In the first year of the study, the Caring for MEGs questionnaire (QT1) provided a starting point and gave demographic and baseline self-assessments of abilities of the students. The group interview (see Chapter five) aimed to gain further insight into students' views of cultural competence and was conducted in the same year.

Volunteers who had limited experience of working with minority groups were chosen for their willingness to participate in talking about a sensitive topic. During the second year of the course, within the Research 1 module, students were shown how to complete repertory grids and the opportunity was taken to use these grids to capture their individual constructs of cultural competence. The grids also enabled the capture of individual constructs of clinical competence. Within the same year, a programme of specific topics was integrated within an established module aimed at increasing students' knowledge and experience of working with minority groups. Assessment of whether these group visits, interactions and experience of working with minority groups, i.e. sessions on 'cultural sensitivity' had been successfully integrated within the module, was captured through students' informal written submissions entitled 'Experiences with minority groups'. At the end of the module, students' overall experiences were obtained through personal accounts and these were submitted as part of normal module feedback. In the final semester of the same year, year two, in an attempt to investigate changes from year one to year two, the Caring for MEGs questionnaire was re-administered (QT2) and similarities and differences were analysed. Towards the end of the final year of the programme, focus group participants were invited back to complete an end of year questionnaire to offer their views of cultural competence within the curriculum and their experience of it within their course of study. This activity marked the final data collection point within the case study. It is recognised that outside of the physiotherapy undergraduate programme, students pursued activities which could have influenced their perceptions and experiences in a number of ways and this is followed up in the discussion.

The number of subjects varied across the different data sets due to the use of purposive sampling, absence and students exercising their choice over whether or not to participate.

This study adopted parallel analysis in that data sets were analysed first separately and then findings were combined and consolidated at the interpretative stage. Use of the triangulation framework assisted in guiding the interpretative stage. In assessing the relative value of the investigations to the overall study, each was considered and evaluated individually and then collectively. Contemplating issues of reliability, validity and limitations were taken into account as discussed in the relevant chapters.

Interpretation of the contributions made by the different investigations

Each of the investigations in Table 3 offer insights into Propositions 1 and 2 and fed into the underlying assumptions of the study which have been identified. They also suggested that students' perception of cultural competence was closely related to their understanding and ability to care for minority groups. Results from the questionnaire at QT1 identified potential areas of concern students had in caring for minority groups. While the questionnaire used the term 'cultural sensitivity' for reasons explained in Chapter five, the term 'cultural competence' was adopted for the interview nonetheless; findings arising from analysis of the latter complemented findings of the questionnaire at QT1: students related limited confidence in communicating and treating individuals from MEGs. The relative

contribution of these findings was considered for their implication in learning and teaching of the topic in Proposition 1. Findings from the interview alongside interpretation of the repertory grids also assisted in framing a perception of cultural competence held by the group.

The majority of students also completed the repertory grids. Results from these provided interpretation of students' constructs of cultural and clinical competence including a rating of themselves on these competencies. Students rated themselves as culturally competent and this finding appears to diverge from the rest of the data where students consistently highlighted limited ability to care for minority groups, limited access to resources and identified specific learning needs in this area. This finding suggests that there is further room for enquiry but it was useful in further informing and contemplating Proposition 1.

Over half of the students submitted commentary on their 'experiences with minority groups' and these were subjected to thematic analysis. Students identified specific episodes of personal interactions and challenges which were consistent and complementary to findings from the questionnaire at QT1 and the interview. (see 'Clinical experiences with minority groups' in year two). These findings also shed light on the propositions and gave indication of learning needs.

Feedback on the teaching of cultural sensitivity within the Clinical Studies module in year two was in the form of 'Personal accounts'. It was voluntary but responses came back from the majority of the group. From the thematic analysis, findings

suggested that exposure to the varied learning experiences could have implications for learning and teaching of the topic. Topics within the module evolved out of the needs identified by the students, influenced by findings from the questionnaire, repertory grids and the interview and would seem to support Proposition 2. The extent to which these were successfully addressed and implications for learning and teaching of the topic in the future is explored in the main discussion. The programme of learning served to increase the social interaction of students working with minority groups. The sessions were confirmed generally as a positive intervention and valued learning experience. The learning context of the classroom enabled students to openly discuss and share resources and although this was not captured in a formal way, sharing confidences and a variety of experiences openly in a learning situation may also have been an important contributory factor in their learning.

Sequential analysis of data from the first year and first term in this second year of the programme yielded different types of data and results which were, in general, complementary and supported Proposition 2. Analysis of data which followed this period also appears to indicate how learning and teaching in relation to Proposition 2 may be considered further. Results from the re-issue of the questionnaire at QT2 (the end of the second year of the programme) were generally similar to QT1. Again, since a majority of the students completed the survey, findings could be said to represent the views of the whole cohort. These were generally complementary and again, were consistent with findings from other areas of the investigation. Although their learning needs remained similar, students appeared

to have increased awareness of these needs in relation to more specific issues and were slightly more aware of additional resources to help them, including use of clinicians. However, the ‘after effects’ responses to the questionnaire at QT2 could not be assigned solely to the effect of the programme of study because on-going curricular activities including workplace experiences could have been influential contributory factors in relation to Proposition 2. Effects of increased exposure to situations which challenge the cultural competence of students and implications for learning and teaching are followed up in the main discussion.

The end of course questionnaire was considered useful in its contribution to both propositions. It was used pre-graduation at the end of the programme of study to assess the exiting views of the students regarding cultural competence. Thematic analysis of this data was based on the responses of nine students, the original interview group. As before, this was recognised as a limited sample of the cohort and their views were considered in relation to both propositions but in particular Proposition 1. The questionnaire gave students the opportunity to reflect on cultural competence within the course and their journey through it. Data showed that students had grown in confidence in a number of ways and had increased awareness of working with minority groups. However, it also confirmed findings from previous investigations highlighting the need for increased interactions of students with minority groups, developing experience in use of interpreters and the continuing lack of resources in teaching and learning of the topic.

Triangulation of the data is often cited as one of the principal ways of addressing bias. Measurement, procedural and sampling bias are areas of particular concern in research. With respect to measurement bias, both individual and group approaches were incorporated in the study and so no one strategy to gain data was employed. Moreover, the investigations adopted a case study approach in an attempt to capture perception and learning and teaching of a particular topic across the curriculum. Individual questionnaires, personal accounts and reported individual experiences with minority groups were balanced against group interview and grouped responses. Themes were generally consistent across the data and these were identified and addressed in the relevant chapters and in the main discussion. Similarly, complementary and any discordant themes from across the repertory grids and the questionnaires were scrutinised. Consideration was given to procedural factors, in particular to factors which could be said to have put subjects under pressure. Attempts were made to address these by adopting different methods and time periods of engagement in the different approaches to collecting the data, and are also addressed under criticisms of the individual studies within the relevant chapters. Whilst bias may be considered to be ever present, its impact is also considered within the reflective writings and discussions in Chapter nine.

The findings within this case study were evaluated for their relative contributions in supporting the two propositions cited. Taken in isolation, each of the investigations offered insight into different aspects of undergraduate physiotherapy views on the topic of cultural competence. Sample size varied across the investigations and

where the sample was small, the extent to which these views could be said to be reflective of the wider group was limited. However, findings from the smaller samples were found to be generally consistent with findings identified in other parts of the study, and this indicated an acceptable level of consistency. Where there was inconsistency, notably in interpreting findings from the repertory grids, this suggested the need for further investigation. Using Erzberger and Kelle's (2003) approach to triangulation, at a theoretical level, findings from this study suggest that there is room for further research to explore other factors which might inform the propositions cited. However, summary interpretations indicate that each of the investigations, to a greater or lesser extent, contributed to developing a picture of how students perceived cultural competence and based on this perception, a programme for supporting learning and teaching the topic appropriate to their experiences can be developed.

Criticisms of triangulation

Arguments persist against triangulation. It has been argued that triangulation does not necessarily overcome incompatibility of research paradigms (Casey and Murphy, 2009). This issue aside, Casey and Murphy (2009) recommend that research questions should be clear and focused, a clear rationale offered and an account of how triangulation was carried out given, including demonstration that each data collection method was complete in itself and that there was rigour in accounting for how triangulation adds to the study. Criticisms might still remain regarding the means by which this was achieved. This investigation began with clear focus in an area which was relatively unknown from which the research

question arose. Bryman (2004) recognises that some research, often qualitative, may not have a stated research question and that care should be taken to avoid the question overly dictating the path of the research. Criticisms could be made that triangulating the data could have limitations in the interpretation of this process.

Guba and Lincoln (1994) also refer to the need for data to demonstrate truth credibility, applicability, auditability and conformability. These elements require the researcher to address congruency of the findings with reality and trustworthiness. Findings within this case study were used to evaluate their relative contributions in supporting the two propositions cited. These need to be also placed within the context of the total reality in which the research was conducted and challenges remain regarding how this can be best achieved.

Triangulation may not necessarily add to the accuracy of results but instead may offer an improved understanding of the topic which is under investigation (Denzin, 1989). In this study, it offered improved focus on the purpose of the investigation i.e. the perception of cultural competence in undergraduate physiotherapists and the implications for learning and teaching. Although tentative conclusions drawn from triangulating the data identified that students held a perception of cultural competence as the need to work appropriately with minority groups and being culturally sensitive when practising in a professional capacity, criticisms of these results might still remain. The literature did not offer views or perspectives to assist in formulating this construct of undergraduate physiotherapy students on cultural

competence. In consequence, there is further scope for research in this area to inform learning and teaching of the topic in undergraduate physiotherapy education.

CHAPTER 9 DISCUSSION

The discussion is divided into four sections. Section one draws on findings from the mixed methods case study in order to offer an evaluation of the perceptions of cultural competence of undergraduate physiotherapy students. This is compared with perceptions of cultural competence of other students found in the literature. In section two, an evaluation of the influences on teaching the topic of cultural competence in undergraduate physiotherapy education including a perspective from government is offered. Section three examines the learning needs of the students and explores possible implications for the learning and teaching of the topic. In section four, based on evaluation of the study and the literature, a discourse which seeks to recognise cultural competence as an integral part of professionalism, state registration and continuing professional development is submitted. It is suggested that an approach which seeks to integrate cultural competence with professionalism should be adopted in undergraduate physiotherapy education**.** The discussions are concluded by identifying future areas for research into the topic.

The research was directed at answering the question ‘How do undergraduate physiotherapists perceive cultural competence and what are the implications for learning and teaching?’

The reader is reminded that the study aims were:

- An exploration and critical analysis of cultural competence in physiotherapy within the literature
- Investigation of the perceptions of cultural competence held by undergraduate physiotherapists
- Investigation and identification of the learning needs of undergraduate physiotherapy students in cultural competence
- Evaluation of the outcomes of the investigations
- Identification of possible areas for future research in cultural competence

9.1 Perceptions of cultural competence amongst undergraduate physiotherapists

Through an interpretive paradigm, perceptions of cultural competence amongst undergraduate physiotherapists were analysed through the use of a mixed methods case study of a single cohort over a three year period. Although there is a dearth of evidence in respect of investigations of this kind within the UK, certain aspects of the findings of this study were consistent with findings of other health care undergraduates found elsewhere in the literature. No studies were found which investigated the perception of cultural competence of undergraduate physiotherapists within the UK. Possible reasons for this may be due to limited familiarity with the topic within the profession, the evolution of alternate terminologies within the UK in relation to inequality and practices addressing it or

the term may be deemed not to be of sufficient significance. A search on the DH website at the time of this study identified one article which articulated cultural competence in health care, ‘Facing up to difference, a toolkit for creating culturally competent health services for black and minority ethnic communities’ (DH, 1996). On the other hand, the term ‘cultural’ is a commonly adopted adjective and it was pervasive within the literature but its association with competence was negligible. It would appear that throughout the explorations, cultural awareness was the preferred term. A lack of familiarity with the term amongst physiotherapists is borne out in the literature which emanates from the relatively few writers on the topic within the UK (Stewart, 2002; Kale and Hong, 2007; O’Shaughnessy and Tilki, 2007; Norris and Allotey, 2008; Yeowell, 2010). The conclusion commonly reached is that this lack of familiarity may be proving detrimental to quality of care for some service users, and thus this may be contrary to the view that the term lacks significance. This evolution of preferred terminologies and practices also appears in other countries and is often associated with the histories of its peoples. For example, the origins of cultural competence in the US is strongly associated with a legacy of racism (Hanley, 1999) while within the UK the rhetoric of equality of opportunity has in its turn pervaded the nations’ literature. However, there is now the suggestion for convergence towards the use and recognition of the one term of cultural competence (London Deanery, 2012).

Although comparisons of research findings may be made, caution should be applied when undertaking analyses across different countries because whilst areas within programmes may appear to be similar, learning outcomes and the

context in which programmes are delivered may be strongly influential on these outcomes. For example, in preparation for eligibility to register with the HPC within the UK and to practise subsequently, individuals are required to graduate from an honours degree programme at the appropriate level. In contrast to other parts of the world where in order to practice, students may be required to have successfully completed a programme at diploma, master's or even doctoral levels. Therefore, not only are there considerable differences in the length of the student journey but the cultural experiences of the students in the same profession may be very different. Given this variability, the practice of physiotherapy varies across the world and these similarities and differences must be borne in mind when research from different countries is being evaluated. In addition, cross-cultural meanings which are attached to individual programmes may also be open to variation in interpretation. Caution should also be exercised in respect of the implications on the validity of instruments used in measuring outcomes.

Repertory grids were one of the main tools used for assessing the perception of cultural competence of the students. They have been used in nursing, for exploring students' professionalisation (Howkins and Ewens, 1999) but no similar studies investigating the topic were identified in physiotherapy. Physiotherapy undergraduates were requested to produce constructs of cultural competence against constructs of clinical competence. The construct of clinical competence was introduced because it was a concept with which students were considered to hold great familiarity and the results suggested that this was the case. The latter also facilitated how the grid was composed and was considered to have the

potential to offer additional insight into students' self-assessment of their clinical development. Students produced adjectives which were common to both competencies but they also presented others which showed clear differentiation. Perceptions of the students obtained from the grids suggested that they had an awareness which was consistent with aspects of developing cultural competence.

The students identified themselves as being more culturally competent than clinically competent, yet the same students assessed themselves as being less able to treat minority groups compared to the majority group (see Chapter five). These two expressions of ability might appear to be inconsistent if being clinically competent assumes cultural competence. However, if it is argued that cultural competence and ability to treat minority groups require different sets of skills and that there are inherent differences between the two competences then this might offer explanation. For example, if it is the case that clinical competence offers a more global approach for assessment of practice whilst assessing ability to care for minority ethnic groups is more specific, then this raises questions as to what the specific skills might be. Students were also at liberty to devise their own constructs and this in itself could have been an influence on the scoring of the two constructs. If, as has been implied 'students don't know what they don't know' the adjectives on which they chose to assess themselves may not have been a true reflection of cultural competence. Nonetheless, the constructs might have been a true reflection of their perception of the competencies at that time.

It is worth contemplating that whilst the students may have been more willing to acknowledge a deficiency in clinical competence by giving themselves a lower score, they may have been less willing to acknowledge specific areas of deficiency in their cultural sensitivity, possibly for reasons which will be explored. It is likely that the purpose of the practice placements were perceived as places for developing and honing skills of clinical competence; therefore, they may have automatically assumed that they were not expected to be clinically competent. Lack of clarity in the required elements of cultural competence and where it sits in the development of the professional skills of undergraduate physiotherapists in practice placements might therefore have been a contributory factor affecting these self-assessed marks.

The students' choice for more wordy and nebulous descriptors to depict cultural competence may also have presented a greater challenge in using them for assessment. Adjectives for the construct were contained in words and phrases such as 'tolerant', 'open minded', 'not ageist', 'not scared dealing with unknown cultures' and 'doesn't feel they are superior' which incorporated evidence of a moral stance. Students may have felt that whilst it may have been acceptable to show themselves as novices in clinical competence, any expression of a lack of tolerance or equal treatment may have been deemed less acceptable, particularly where the elements expressed were considered to be important pre-requisites for all health care practitioners.

The links between the constructs individuals hold, competence and behaviour are not clear. Cross (2001) identified that competence can only be assumed through observed behaviours which are thought to be indicative of constructs held. This could mean that the way an individual behaves may be a demonstration of their competence and that it is indicative of the way they construe or perceive the world. Competence is said to exist at varying levels and Stengelhofen (1993) itemises it by way of professional competence in knowledge, skills and attitude. Constructs produced by the students could be seen as a reflection of these attributes. Their perception of clinically competent practitioners concurred with the literature in the way they used adjectives such as 'experienced', 'good communicators' and 'knowledgeable' (Cross, 1995). There was no comparable way of verifying students' perception of cultural competence since unlike clinical competence, standardised constructs do not appear to exist in the literature. This association of constructs with behaviour is an area which remains relatively unexplored and ripe for future research (Cross, 2001).

It is postulated that students could have presented constructs of behaviours to which they aspired. It is also conceivable that at a subconscious level, although student aspirations may be altruistic, behaviours they present may be influenced by underlying prejudices some of which the student may be unaware (Stuber et al, 2008). Dealing with the subconscious presents further challenges in learning and teaching strategies adopted in developing the topic of cultural competence in curricula. The higher marks which students gave for their cultural competence may have been indicative of some degree of dissonance between their constructs and

behaviours. Triangulation of the repertory grid data with data from other areas of the investigations, for example the group interview, and evaluations of the Clinical Studies module, endorsed this inconsistency between students' perception of their self-assessed cultural competence and aspects of behaviours in which they voluntarily identified limitations in their skills. There is room for further exploration of what appears to be a clear gap between thinking about the problems faced and self-assessment of cultural competence. The behaviours of the students were not the main theme in this investigation and therefore further speculation in this area was curtailed.

9.2 Influences on the learning and teaching of cultural competence in physiotherapy education

Attending to the subconscious and how these may be displayed in behaviours has already been alluded to in the previous section and requires further consideration in the learning and teaching of cultural competence. In addition, the study has highlighted questions of how cultural competence can be best situated in physiotherapy education, especially when the overall picture is clouded by the discussions around the identity and practice of physiotherapy and its supporting knowledge base (Robertson, 1996; Higgs and Titchen, 2001). Historically, practice has been centred on a biomedical model of care but there is increasing pressure for the inclusion of sociological aspects of care (Lundström, 2008), greater user and public involvement and greater patient-centredness (NHS Institute for Innovation and Health Improvement, 2010). O'Shaughnessy and Tilki (2007) highlight the problems of the omission of cultural competence in undergraduate

physiotherapy curricula and as a consequence, subsequent and increasing problems with the topic at postgraduate level. As practitioners attempt to gain more in-depth knowledge of factors influencing rehabilitation, research into topics in relation to cultural diversity has increased (Hunt, 2007). In this climate, undergraduate health care programmes are continuing to highlight associated problems and offer possible ways in which the topic of cultural competence might be studied. Helman (2007) cites modern anthropology and clinically applied medical anthropology as a focus for the study of the topic.

In nursing, cultural competence has been studied as a topic in transcultural nursing where the focus has been on culturally sensitive care and the societal structures which impact on that care (Papadopoulos et al 2008; Bednarz et al, 2010), while in medicine, the search continues for a coherent educational framework through which the topic might be addressed with medical students (Dogra, 2005). Kumagai and Lypson (2009) suggest that there is need for a competency where the outcome is ‘social justice’ for all members of society. These writers also concur that the process must be coupled with resultant action especially in fields where practitioners are seeking to incorporate humanistic and social issues into practice. Cultural competency seeks to find and build a platform where all stakeholders begin to explore input and output measures in multi-agency care systems and analyse the consequences for each individual. Within physiotherapy education, the picture is no different. The ‘clinical’ problem clients bring is embedded in who they are, i.e. their identity, and hence attempts to disentangle it from identity renders threats to effective treatment. I surmise that

since there is no one process which equips the individual to function in a culturally competent manner, the needs of the practitioner, service users and the processes all require mutual analysis and to be addressed in an outcomes led manner which is transparent. The view forwarded is that the will and motivation to actively seek out and address these actions is paramount when embarking on undergraduate programmes aimed at developing cultural competence.

Romanello (2007) in writing about integrating cultural competence in physical therapist education cites the importance of faculty members believing in their mission. In this study, enthusiasm to develop the task was taken on by the curriculum team as a whole, but I was the main driver. It is still the case that there is a question of commitment by accreditation bodies to address the topic (Campinha-Bacote, 2008). Confirmation and recognition of cultural competence as a part of developing as a physiotherapist in the undergraduate curriculum by major stakeholders and validating bodies is not evident. A much deeper exploration of mind-sets, behaviours which take into account individuals' ability and flexibility to adapt to change may be needed to spur further development (Brennan and Cotter, 2008). Influences of a competence-based career framework as promoted by government (DH, 2008b) could be useful although there are on-going debates regarding how this competence approach is to be applied in physiotherapy. The framework has been criticised as being reductionist (Talbot, 2004), but it could assist in the mutual identification of outcomes in which service users and practitioners can identify a pathway of care.

The DH, Strategic Health Authorities, other public bodies and publications such as the Knowledge and Skills Framework, National Vocational Qualifications, NHS Institute for Innovation and improvement and the Skills Escalator all refer to a theme of equality and diversity which show varying but important levels of the relevance of the equality agenda to undergraduate curricula. However, there are additional problems because the term equality and diversity is being used inconsistently. Amin (2008) winner of the DH-funded '2006 Mary Seacole Development Award' identified that there was marked lack of knowledge about equality and diversity in a number of Primary Care Trusts (PCTs) and that this could result in a number of them failing to meet core requirements of the Knowledge and Skills Framework or Healthcare Commission's Standards for Better Health. However, more importantly she makes the link regarding unifying training in this area and CPD (continuing professional development) in order to achieve cultural competence at all levels. Her research highlights one of the many issues regarding the use of the term where writers may allude to the existence of the term often injecting it into their script without offering analysis or contextual definition. Amin defines equality as creating a fairer society backed by legislation, and diversity as recognising and valuing difference, stating that these two terms are not interchangeable. I forward the view that cultural competence provides an overarching term which could serve to encompass and make sense of this interchange between equality and diversity and that clarity in all three terms is required within curricula.

The London Deanery continues to make reference to the omissions of national guidance on the topic of cultural competence (London Deanery, 2012). It may be that as a consequence, professions will continue to be at liberty to develop their own approaches and terminology which could perpetuate on-going inconsistencies in health care practice. In countries such as the US and Australia, regulatory and professional bodies of undergraduate health care programmes have attempted to speak with one voice on the topic and have produced national guidelines with the intention of monitoring progress against outcomes. Adoption of a similar approach within the UK is worthy of consideration. In a report by Central and Northwest London NHS Foundation trusts, one of 17 Focused Implementation Sites created at the initial stages of the DH's five year 'Delivering race equality in mental health', cultural competency training was put forward as a national recommendation (DH, 2005). The NHS's new Equality and Diversity Council convened for the first time in October 2009 and it is possible that this could mark the start of activities which could bring greater cohesion to the understanding of cultural competency on a national stage. Quality, Innovation Practice and Prevention (QIPP) work streams, now operating at a national level, could also be usefully guided in becoming more proactive in the delivery of culturally competent programmes within health care.

Guidance on the learning and teaching of cultural competence for universities and colleges is absent. Assistance in diversity training is offered but it is often limited in its application to culturally competent practices. Institutions use the Framework for Higher Education Qualifications' (FHEQ) reference points from the QAA as a guide

to the quality of their programmes. Without the topic being identified, measures of quality outcomes for the topic in different programmes will remain obscure.

There are recognised constraints and dangers in becoming too prescriptive in the learning and teaching of topics within curricula and cultural competence is no exception. Within undergraduate physiotherapy curricula, variations in contact hours, subject content, learning outcomes, modes of assessment and evaluation are all subjected to the choices made by individual curriculum teams across the UK. However, as in the case with the topic of diversity, the QAA could contemplate a standard definition in their guidance. Given that, the will and motivation to develop educational thinking around the topic and its inclusion within the curriculum may be strongly influenced by staff within those teams (Campinha-Bacote, 2008), a lack of guidance could continue to perpetuate limited or no implementation of the topic within HE programmes.

Government policy on public health is also currently influencing discussions within physiotherapy and undergraduate physiotherapy curricula. Over the last two years, as part of the attempts to improve the nation's health, the government has made public health a top priority and the DH has endorsed development of the Public Health Skills and Career Framework (Skills for Health, 2008). This framework is said to be a tool for describing skills and knowledge required by health care practitioners across all domains and levels of the public health workforce with an aim to influence wider determinants of health. The physiotherapy profession is currently attempting to map skills held by its practitioners against the needs and

requirements identified within this framework (CSP, 2011b). The profession recognises the enormous importance of its role in meeting this national challenge and has embedded public health within its 'Public Health' programme (www.csp.org.uk). The Framework recognises the impact on communities and populations by professionals whose practices seek to influence the health and wellbeing of those individuals. It offers an opportunity to assess the competence and/or gaps in the competence of the workforce but more importantly, it offers commissioners of services, education and training opportunity to inform action of their day-to-day activity.

The Framework recognises that for a long period of time, professionals had their own standards and competencies set in individual training routes, and that there has been a lack of consistency and coherency of vision across the whole of the public sector in developing a workforce which is fit for purpose to tackle health inequalities. It holds the potential to offer an opportunity to gain coherency of approach regarding cultural competence across the health professions. Within it, knowledge and competencies have been linked to qualifications and training across the UK and they have been designed to inform development. However, a criticism of the document is that although it gives due recognition to practitioners having knowledge of how cultural differences might impact on factors such as health, wellbeing and quality, unlike the myriad of other competencies offered throughout the document, it offers no overview of the competency requirements for any of the nine framework levels listed in this area. It is my view that the opportunity to offer levels of cultural competence has been missed and that this

omission may present oversight of an important issue which could continue to fuel a lack of coherency in how the topic is managed by health professionals. It appears that the essence of one of the aims of the documents to make explicit the knowledge and competencies required in achieving quality of care may have been lost; a factor which conflicts with the main aim of the framework i.e. to bring coherency and consistency of approaches across the workforce.

Joint Strategic Needs Assessments (JSNA) have been produced by LAs and PCTs to establish the current and future health and wellbeing needs of populations that will show improved outcomes and reduction in health inequalities. The CSP recognises that in order to meet objectives outlined in the Annual Report of the Chief Medical Officer, physiotherapists need to be aware of lifestyle issues which affect health, for example working with diverse communities, developing health programmes and services, reducing inequalities and increased familiarisation with the health profile of local authorities. The report identifies key innovations to tackle local inequalities, promoting equality and providing services centred on individual needs. Priority in developing culturally competent skills appears to be one of the requisites which lie at the heart of much of this activity.

Around the UK, there is on-going work to measure the quality of physiotherapy provision and there are clear implications for undergraduate curricula. Core dimensions of quality in health care within the UK are cited as effectiveness, access and timeliness, capacity, safety, patient-centredness and equity (The Health Foundation, 2009). A wealth of information is available on patient reported

outcome measures and quality of life indicators; however, this would appear to be inconsistent with other sources of literature which state that there is little evidence from a patient perspective around notions of cultural competence (Bowl, 2007; Elkan, 2007). If this is the case, then it raises questions around whether quality of provision, including physiotherapy, has taken full and accurate account of users' perspectives especially in relation to cultural competence. Further analysis of these accounts may be warranted.

9.3 Identified needs of the students

The learning needs of the students were clearly expressed across a range of the data. Responses to QT1 showed a variety of issues which were consistent with the interview data and personal accounts. Evidence from the literature suggests that the topic of cultural competence and issues surrounding its development, learning and teaching within the undergraduate curriculum in the UK has suffered from a lack of structure and identified body of knowledge (Hunt, 2007; O'Shaughnessy and Tilki, 2007) and this may have affected how the topic is perceived within the profession. The learning and teaching of cultural competence and similar topics which are rooted in social science have been restricted in both depth and breadth within physiotherapy undergraduate curricula. Hence, at an undergraduate level students' ability to critically analyse social theory and relevant social issues may have been limited relative to other topics within the curriculum. This may have been compounded by the fact that historically, physiotherapy undergraduates have been recruited from a pool of students where their

educational backgrounds have been firmly rooted in the pure sciences because of course requirements (Green and Waterfield, 1997).

By its nature, the subject of cultural competence raises certain sensitive topics within a sociological perspective where issues of health inequalities, bias, discrimination and prejudice are examined. There is limited evidence to show the extent to which these topics are examined as an aspect of cultural competence within curricula. Levels of discomfort and sensitivities were evident in the learning and teaching of the topic and some of these aspects were captured in data such as the group interview. Use of flexible approaches to learning and teaching in the day-to-day delivery of the sessions were required such as active exposure to sensitive issues, conflict management, managing anxieties for staff and students. Use of reflection and experiential learning are commonplace in undergraduate physiotherapy curricula and in the workplace and was a part of the student journey which was formally tested in the Clinical Studies module assignment. Wong and Blissett (2007) suggest that reflective accounts may also be helpful in mapping the student journey. It is possible that were the writing of these accounts on the topic established, development of students' constructs could be followed and analysed. Reflective accounts could also be considered as a useful way of assessing how the crucial link of the user's perspective is considered in the dialogue, an important missing link which is currently missing (Black and Jenkinson, 2009).

It was not known if during the students' experiences within the workplace, the topic of cultural competence arose, or the extent to which clinical educators felt at ease

in dealing with the topic. Many clinicians have had relatively little exposure themselves in dealing with the topic and in addressing their own sensitivities and they find it challenging to explore these areas with students (O'Shaughnessy and Tilki, 2007; Lazaro and Umphred, 2007). Since the views of clinicians were not sought, further analysis of their views could not be taken into account in this investigation. Nonetheless, students highlighted situations in their responses to QT1 where clinicians and/or colleagues may have had problems in dealing with patients from minority groups. Therefore, the extent to which they are able to meet the needs of students could also have been compromised. O'Shaughnessy and Tilki (2007) recognised this under-preparedness of therapists for practice in this area and called for educational support for clinicians on this topic.

Developing as a professional is often gained through socialisation (Du Toit, 1995) and role models such as clinicians are often seen as major contributors in that journey (Cross, 1995). If role models are perceived as being deficient in certain skills, it raises the question of the consequences for learners who are using the models as their frame of reference. Compounding this issue is the fact that within physiotherapy there are an increasing number of extended scope practitioners i.e. physiotherapists with expertise beyond the commonly recognised boundaries of practice and who also have responsibility for student learning in their clinical placements or in the workplace. These practitioners may present as the students' key or sole supervisor yet, although it may have been established that they hold expertise in specialist areas, their levels of culturally competent practices are also not known.

Physiotherapy continues to be one of the most popular courses in undergraduate health care education and there is an increasing rise in demand for pre-registration courses for graduates. Pre-registration students hail from a variety of backgrounds and as postgraduate students, they present further challenges to developers of physiotherapy curricula. Current demands for two year pre-registration degree courses trigger issues regarding styles and delivery of learning and teaching and levels of proficiency which can be achieved in a reduced training and educational timetable. Currently, it is not known whether cultural competency is a feature of any of these programmes, how it is perceived or how and to what extent the topic is being contemplated as part of the learning outcomes of the students who fall into this these groups. Given that graduates from these programmes will be practising in similar environments to graduates emerging from three year programmes of study, consideration of the issues cited concerning developments in understanding the sociological context of health within physiotherapy curricula may be equally applicable to these programmes. Ensuring that cultural competence becomes a feature of all physiotherapy programmes requires the attention of the CSP and HPC to address the topic with the relevant HEIs but the input from these national bodies have been shown to be varied and limited.

Results from triangulating the data identified that resource needs of the students was a major issue. Although they identified support in terms of materials such as books, videos, pamphlets and booklets, the most commonly identified human resource was in the help they received from qualified staff. The study suggests

that in incorporating and developing cultural competence within the curriculum, consideration will need to be given to implications for the practice settings. Within the literature, the issue of resources for supporting the learning and teaching of cultural competence has been variable (Kraemer, 2001; Kale and Hong, 2007) but more recently, anecdotal evidence suggests improvement and developments of the internet has increased the availability of information such as NHS Ethnicity and Health and CultureVision. They appear to offer potential support for learning and teaching the topic in that real life examples, guidance documents and evidence-based material are amongst the resources cited as being on offer (CultureVision, 2010; NHS Evidence, 2012). However, closer examination of some these materials show that access may be restricted to subscribing members as in the case of CultureVision and questions remain regarding the updating and authenticity of the materials. Similarly, a number of e-learning materials including YouTube videos are becoming increasingly available and offer scope for further evaluation of approaches in presenting, learning and teaching of the topic.

9.4 Linking cultural competence, quality of care, professionalism and curricula

Measures of health care quality are far-ranging, complex and multidimensional. The study did not explore the perceptions of users but instead identified the self-assessed perspectives of the abilities of undergraduates in their cultural awareness and cultural competence. Delivery of quality of care requires culturally competent practice and as such, users' judgement may be seen as fundamental in assessing contributions to the process. It is thought that measures which aim to

evaluate patient's experience of health care may be open to more robust interpretation than their level of satisfaction with a service but that appropriateness of instruments which rely on the user's judgement of best fit is one of the key criteria (Fitzpatrick et al, 2006). Users' views of professionals may vary as well as the level of skill the professional is able to offer. It is also recognised that health care professionals may be excellent in one area while being deficient in another and that a portfolios of activities may be needed to demonstrate professionalism (Wilkinson et al, 2009). By this token, a professional could be deemed to be lacking in cultural competence. The issues that this raises links of the notion of what is deemed to be professional, and what the required competences might be.

Cultural competence as an implicit part of professionalism has been alluded to (Wilkinson et al, 2009) but more importantly, cultural competence and patients' views may also be considered to be important elements on which professionalism rests. As in the development of cultural competence, the development of professionalism incorporates a number of complex social processes and so a juxtaposition of the two notions offers a useful basis for discussions on how related educational approaches, activities and evaluation might influence effective development of undergraduate physiotherapists as competent health care professionals.

There is little consensus in the literature on the meaning of professionalism (Baumann and Kolotylo, 2009). It is said to be complex and addresses contextual, environmental as well as professional behaviours (Blue et al, 2009). It was alluded

to by Flexner in 1910 and his expositions have influenced a number of writers researching the topic. Hafferty and Castellani (2010) in writing of Flexner's approach pin-point a number of factors in understanding professionalism. Intriguingly, many of the same factors are also embodied in the notion of cultural competence. For example, Flexner's approach to professionalism is said to be empirical i.e. borne out of guided experience, interdisciplinary, drawing on occupations other than medicine, society and social forces. These were viewed as powerful evolutionary influences conceptualised at both individual and professional levels.

In a similar way, these attributes appear to be apparent in the case of cultural competence. Writers on the topic of cultural competence such as Betancourt and Green (2010) support the view in a more direct way in stating that cultural competence is central to professionalism. However, there are limitations to the instances where analysis and evaluation of professionalism can be positioned alongside cultural competence or vice versa. For example, a view taken of professionalism is that it is self-regulatory and that individuals are in control of their own body of knowledge, encouraging client dependency or even paternalism (Irvine, 1997). It is clear that if, as Wynd (2003) postulates, one of the primary tenets of professionalism is public service, then both cultural competence and professionalism have implications for the way in which they are viewed and positioned in the public domain. Health care professionals are considered to have the competence and skill to deliver a public service at the point of registration. This is evidenced in physiotherapy by entry onto national and public registers of the

HPC and CSP. However, if cultural competence is considered to be central to professionalism then currently, at the point of registration, there is no explicit measure of cultural competence and this poses a possible cause for concern.

It is suggested that cultural competence should be made more explicit at the point of registration in physiotherapy for a number of reasons but primarily because a number of writers have made important and similar observations which identify that cultural misunderstandings have increased because health care practitioners are increasingly challenged by working in cross-cultural communities (Okougha and Tilki, 2010), health care strategies are at risk of failing certain service users because health care systems do not reflect culturally competent practices (Anderson and Pickering, 2008) and certain groups of individuals across the world are known to be at risk of receiving ineffective care due to a lack of cultural competence (Department of Health Victorian Government, 2009). It is highly likely that the effectiveness of health care practitioners will continue to be challenged in working with individuals in cross-cultural situations because of inevitable changes in the characteristics and dynamics of communities.

The route to identification as a professional and subsequent registration on a professional register varies but it is commonly and strongly focused on personal values, upbringing, professional role models, structure of work placement experience and formal instruction (Park et al, 2010). The ways in which individuals are said to develop cultural competence appear to be very similar in that it is influenced by upbringing, exposure to different communities, work placement and

formal instruction (Betancourt and Green, 2010). Thus, it seems that the learning processes and the extent to which day-to-day experiences in an organisation influence development may be common to both. The consequence of this is that in making decisions on relevant content within programmes, identifying specialist knowledge, ascertaining and evaluating students' level of attainment and assessment of attainment in the clinical field, the connection between cultural competence and professionalism may be taught as interlinked components in developing as health care professionals, and that attempts to separate learning and teaching of the two entities could render the process to be less effective.

Evidence of continuing professional development is now being used as a standard for assessing the competence of professionals and for maintaining registration within the AHPs. As yet, there has been no explicit call for CPD to be linked in any way to the development of cultural competency. The assimilation of CPD and registration could be used as a practical tool to establish cultural competence as a part of the HPC re-registration process. As Calman (2000) indicates, engagement with CPD holds significance not only for the practitioner but for the people they treat. Ability to reassure the public in an overt manner that registered health professionals and in particular state registered physiotherapists are able to demonstrate culturally competent skills could be viewed as an important part of the public duty of the HPC.

Physiotherapists have identified cultural competence as an area in which they require additional support in order to show their continuing professional

development in fulfilment of the requirements for Core Dimension Six of the Knowledge and Skills Framework (CSP, 2006). Bullock et al (2003) contend that CPD should be chosen in a way that is likely to impact on practice and improve patient care rather than leaving individuals within their comfort zone. The HPC accepts evidence from potential registrants of their activities within the KSF as demonstration of competence. However, given that there is a clear lack of confidence by some physiotherapists in how best this might be demonstrated, it is suggested that in making cultural competence an explicit part of undergraduate programmes and an overt part of CPD activities in the workplace confidence of physiotherapist in this area might improve.

Expressions of professionalism and activities for CPD in physiotherapy will be influential on how the undergraduate curriculum evolves. The literature is sparse on what constitutes appropriate curricula content in developing cultural competence in physiotherapy. However, guided by data obtained from this study and related research identified in the literature, a guide to topic areas considered worthy of inclusion is presented in Figure 11. The suggestion does not purport to offer solutions for all programmes but the proposed topics are rooted in a context which is grounded in experiences of physiotherapy practice and offers areas in which developers of curricula might begin to identify learning outcomes which may be tailored to fit individual qualifying programmes. The levels are in accordance with QAA levels for qualifying programmes in higher education for a Certificate in Higher Education, Foundation Degree and a Bachelor's Degree with Honours.

Figure 11 Cultural competence in undergraduate physiotherapy – A guide to relevant topic areas

Topics	Sources (From the literature and recommendation from researcher's background knowledge
Level 4 (Certificate of Higher Education)	
Investigating and identifying inequalities, sensitivities, prejudices, discrimination and other factors affecting care	Bhopal (2009), Clark (2009), Taylor and Marandi (2008), Bogg et al (2007), Rosa (2007), Kraemer (2001), Cilfford et al (1999), DH (1998), DH (1980)
Equality legislation	DH (2010), Disability Discrimination Act (1995) and Amendment Act (2005), Recommended from own background knowledge
Bias, prejudice, discrimination	Seeleman (2009), Thornicroft at al (2009), Stuber et al (2008), Wright and Lubensky (2008)
Diversity and self-assessment	Lie (2009), Kale and Hong (2007), Chapters 2.2, Chapter 5
Addressing inequalities and health disparities – gender, race, sexual orientation, disability, age, religion	Berman and Paradies (2010), Dogra (2010), DH 1998, JSNAs
Nature of cultural competence and professionalism	Hafferty and Castellani (2010), Davis (2009), Hawkins (2009), Campinha- Bacote (2003, 2007, 2008)
Defining and developing cultural competence	Cuellar et al (2008), Papadopoulos (2006), Srivastava (2007), Stewart (2002), Lister (1999)
Investigating HPC and CSP policy on cultural competence and related issues	CSP (2007), (Requires further research)
Identifying and developing CPD evidence, reflective practice in cultural competence	Kinsellla (2010), Kumagi and Lypson (2009), Gersch (2008), (Requires further research)
Level 5 (Foundation Degree)	
Culturally competent skills – within clinical reasoning, exploring workplace	Brennan and Cotter (2008), Norris and Allotey (2008), Romanello (2007), Caffrey et al (2005)

Topics	Sources (From the literature and recommendation from researcher's background knowledge
practices	
Exploring service users' experiences	Bednarz et al (2010), Black and Jenkinson (2009), mason and Sparkes (2002)
Self-assessment and investigating impact on care	Okougha and Tilki (2010), Clifford et al (1999), (Requires further research)
Challenging practice – stereotypes, discrimination, prejudice	Bentley et al (2008), Papadopoulos (2006)
Exploring perspectives of care for identified groups	Leavitt (2010), Srivastava (2007), Genao (2009)
Challenging notions of cultural competence	Leavitt (2010), Romanello (2007)
Developing and analysing CPD evidence	(Requires further research)
Level 6 (Bachelor's Degree with Honours)	
Evaluating emerging inequalities	Smith et al (2009), Ross and Schneider (1992),
Exploration of measures of cultural competence	LaVeist et al (2010), Purnell and Paulanka (2008), Campinha- Bacote (2007), Hughes and Hood (2007), Pearson et al (2007), Sue (2001)
The interface of clinical competence and cultural competence	Seeleman et al (2009), Capell et al (2008), Hunt (2007), Fitzpatrick et al (2006)
Cultural competence from an international perspective	Larso et al (2010), Main et al (2006), Papadopoulos (2006), Gerish and Papadopoulos (1999), Leininger (1985)
CPD evidence, evaluation, cultural competence and self-assessment	Doorenbos et al (2005), NHMRC (2006), Boylan and Grant (2004), Engebretson and Littleton (2001),Meleis (1996)
Exploring moral validity, critical consciousness in practice	Dixon et al (2010), Kumagi and Lypson (2009), Bogg et al (2007), Cook (2006), Brockner (2001), Brach and Fraserirector (2000)
Policy and procedures in cultural competence	DH (2010), O'Shaughnessy and Tilki (2007), DH (2005), DH (1996)

Specifications of undergraduate physiotherapy programme are validated and approved by a number of professional bodies including the HPC, CSP and home institutions. Required standards are further articulated by the QT1A Academic and

Practitioner Standards in Physiotherapy. The FHEQ in England, Wales and Northern Ireland (QAA, 2008) for qualification at Level 6 offers a clear standard for universities to develop programmes at this level. The performance of a student as described by the FHEQ at level 4, for example, relates to the ability to evaluate the appropriateness of different approaches to problem solving, developing skills in a structured environment and communicating results of work accurately, compared to a student at level 6 who is required to have qualities of transferrable skills in decision making in complex and unpredictable contexts and to exercise initiative. These distinctions may be applied to the topics identified and to their assessed outcomes. It is not possible at this juncture to offer detailed scenarios of how this might be done, but it is envisaged that future work could offer further developments in this area.

Although, there is agreement within the UK that undergraduate physiotherapists and other health care professionals should develop their ability to care for minority ethnic groups and diverse groups (Dogra, 2005; Bentley et al, 2008), there remains a lack of consensus and a great deal of confusion about the way in which this should be taught and the appropriate terminology to be adopted. There is also much debate in the approaches that might be used (Hughes and Hood, 2007; Cuellar et al, 2008; Hamilton, 2009). Approaches to learning and teaching adopted in this study rested on reflective practice and experiential learning and on my abilities as a lecturer with many years of teaching experience to adapt and adopt different approaches. The suggestion forwarded here is that using a framework which encompasses notions of professionalism and CPD might serve to embed

the concept at the heart of the professional skills in physiotherapy and into its central processes of clinical reasoning and clinical decision making. In turn, this could offer exposure to how the topic is perceived in practice. This idea is explored later in this chapter.

In terms of additional strategies for teaching the topic, based on this study, the view is forwarded that serious consideration should be given to the use of personal constructs as a learning and teaching tool in understanding the topic within the curriculum. It offers useful self-assessed insider views as a point of reference. Authors agree that the frame of reference or self-awareness an individual brings to the learning and teaching platform is fundamental to the understanding of a topic (Lou and de Leon, 2008; Romanello, 2007). Programmes can fail if inappropriate approaches are adopted. Strategies used in the learning and teaching of cultural competence in the past have included lectures and talks, and these have been applied in workshops around topics such as antiracism, antidiscrimination and more recently, equality and diversity. It is suggested that many of the workshops and induction courses have been unsuccessful because they have failed to take account of the constructs which individuals bring with them. The constructs identified by the students, for example ‘not’ being sexist, racist, etc., are important features of the constructs which they envisage as being important. Approaches which fail to take account of personal views and potentially defensive stances in dialogue are at risk of failing.

There are difficulties in striking a balance between unavoidable conflict and discomfort and continuing in a 'business as usual' manner. The learning and teaching of the subject needs to be cognisant of the learners' attempts not be seen as judgemental, ageist, racist and so on as they strive to increase their competence, even if behaviours appear to conflict. Approaches to the learning and teaching of cultural competence, require a safe environment in which individuals feel at liberty to test their moral persuasions and prejudices. Strategies may include creating ground rules, increasing diversity awareness, developing a personal stance, small group work, case studies, investigating patient journeys, developing portfolios, reflective practice, managing evaluation/feedback and a number of these areas were usefully adopted in this study. These are approaches which already exist in many undergraduate courses and there should therefore be little difficulty in adopting them in the teaching of the topic.

I concur with Kumagai and Lypson (2009) that teachers should act as 'facilitators of exchanges' in so doing. They should be in a position to stimulate critical reflection, critical analysis, challenge biases, prejudices, assumptions, manage cognitive disequilibrium and offer their own experience in developing their own cultural competence and experience. It should be recognised that the status of teacher and learner might be challenged when questions of analysing self and biases arise. Students should feel comfortable that in their development of managing areas of contention, discomfort and dissonance are implicit in the process of learning and that 'errors' made in learning will have no bearing on the marks attributed in their formal assessment. They should be assured that

achievement of the stated learning outcomes is the ultimate goal of the learning experience.

The suggestion is that cultural competence is an identified part of developing professionalism which may be developed on a number of levels and incorporated into a clear learning and teaching strategy which identifies specific goals for the learner in a pathway for life-long learning and continuing professional development (CPD). It is postulated that just as the learning and teaching of anatomy and physiology forms an important part of the foundation of physiotherapy knowledge in contributing to developing as a professional, growth in cultural competence from novice to expert levels is also an important part of that development. Similarly, expert practitioners are identified by their possession of a wide breadth of experience, heightened intuition and ability to home in on the root cause of problems without too much wasteful side-tracking (Benner, 1982), so might the expert in cultural competence be seen to possess similar qualities. The encounters and organised knowledge base on which experts are said to rely in efficient problem solving through pattern recognition (Arocha et al, 1993) also highlights the need for students to develop cultural competence through gaining wide practical experience of meaningful interaction with different cultural groups and so develop a rich knowledge base. However, it is recognised that as it is difficult to define ‘experts’ and ‘novice’ generally (King and Bithell, 1998) and so in a similar way, it might be difficult to define experts and novices in cultural competence.

The political climate and other contemporary issues surrounding the development of laws on racism, ageism, sexism, disability, gender and other cultural issues has left a lasting legacy of 'political correctness' and a defensive stance in the minds of individuals and the positions which they hold on some of these issues (Bednarz et al, 2010). They have left challenges for creating effective learning and teaching strategies on controversial topics and how they may be effectively addressed in undergraduate health care curricula. The use of repertory grids roots the data in the culture of the individual and makes the learning and teaching live and current. In this study, they enabled students to offer an insider view of their world on clinical and cultural competence and the challenge now is for developers of curricula to find ways of addressing some of the difficulties highlighted not only in this study but also those which continue to challenge the way sensitive issues are taught in undergraduate curricula.

9.5 Addressing fundamental questions on the integration of cultural competence into physiotherapy

Embedding the development of cultural competence into developments in curricula which are based on professionalism has the potential to contribute to the process of professionalisation and continuing professional development in physiotherapy practice. The practice of physiotherapy and its professionalisation is rooted in the ability of practitioners to develop fundamental skills pertaining to practice and in taking them beyond traditional boundaries. Richardson (1999) makes a differentiation between professionalism and professionalisation. She offers the concept of professionalism as having features of occupations that have made

claims to being professions by identified traits in its members. This view of professionalism is endorsed by other writers who see professionals as self-regulating, controlling their own body of knowledge, regulating their members and giving life to professional values (Buyx et al, 2008; Black, 2009; Davis 2009). On the other hand professionalisation is seen as a more dynamic process of working towards certain goals and is viewed from both an occupational or individual level. It is seen in terms of enhancement where the status quo is challenged and the discipline is developed through the performance of its practitioners (Sparkes, 2002). In this process, physiotherapy consultants, extended scope practitioners and physiotherapy specialists have pursued and honed their skills in areas of the NHS other than physiotherapy per se and are helping to redefine the profession. In contemplating how cultural competence might be embedded into professional practice on a conceptual and to some degree on a practical level, it would seem consistent with this view that in challenging the status quo, use of a fundamental approach in clinical decision making and reasoning within physiotherapy could provide a useful tool by which to incorporate it into practice.

Within the physiotherapy profession, clinical decision making and reasoning is said to lie at the heart of practice as an identifiable skill (Smith et al, 2008). Clinical reasoning is said to incorporate processes of cue identification, hypothesis generating, cue interpretation and hypothesis testing (Epstein et al, 2002) with an emphasis is on hypothetico-deductive reasoning or pattern recognition (Plummer et al, 2006). However, Smith et al, (2009) support the view that this process may be limited and the use of collaboration with others where the patient is a focus of

the decision making might be more appropriate. I concur with this view and suggest that consideration should be given to extending clinical reasoning beyond its standard application to ‘clinical features’.

The practice of clinical decision making offers increased scope to consider and analyse factors which are known determinants of health, for example educational status, sexuality, gender, ethnicity and health beliefs, but more importantly, it places the user at the heart of the process. The skill of physiotherapists to generate a differential diagnosis and to treat using factual evidence through the use of clinical reasoning has long been a feature of practice but less apparent is how cultural competence has been demonstrated in the process. It is has been shown that individuals from minority ethnic-racial backgrounds receive less accurate diagnoses (Fortuna et al, 2009). Assimilation of cultural competence into clinical reasoning and clinical decision making could readily contribute to the making of more meaningful differential diagnoses, improved diagnosis and service-user satisfaction. However, determining appropriate levels of student ability to carry out clinical reasoning would require alterations in approaches to learning and teaching and in the methods of assessment adopted. It would require combining the development of ability to critique information which has been generated, skills of self-reflection and learning the processes of reasoning which clinicians adopt. Smith et al (2008) identify that use of collaboration, not only with the service user but with other professionals in the clinical decision making process, could also assist and serve as an important function especially for less experienced practitioners.

The demonstration of professionalism may be said to be a constituent part of professionalisation. In the latter, the ability of the professional to advance their profession, appraise its status and to redefine it may be viewed as making a contribution to the process (Richardson, 1999). It is suggested the adoption of cultural competence as an identifiable part of clinical reasoning and decision-making skills has the potential to contribute to that professionalisation process. It is postulated that embodiment of the practice of cultural competence with its potential to nurture values, attitudes and behaviours, its capacity to bring about organisational change and to develop mutual benefits for the profession and users of health care services should be advanced within the profession. Its inclusion as part of clinical reasoning and clinical decision making offers scope in which it could be made explicit.

However, if the aim of developing cultural competence is to address issues pertaining to equality, then in the developments of interventions as identified by Mansyur et al (2009), there remain further areas for contemplation in this context. The authors make reference to socio-cultural influences on a number of levels e.g. interpersonal processes, and identity at a micro level, the context in which much of this study was explored. They argue that two other identified levels of influence, the meso level where cultural norms and social institutions operate and the macro level of political, environmental and historical contexts, also have to be taken into consideration and only when this has been done is it possible to put the right interventions in place. Undergraduate physiotherapy programmes undergo change

over time and historically, have strong links to national workforce planning and other operational issues within the NHS. Current political changes alongside major restructuring in how health care is delivered, and institutional changes within universities will directly affect the provision, content and structuring of the delivery of undergraduate health care programmes. How these might affect future developments in physiotherapy is difficult to predict.

9.6 Considering assessment of cultural competence in curricula

Identifying levels of attainment require measures of assessment. The study did not set out to assess the cultural competence of undergraduates but rather to gain their views and perception of the topic. In so doing, self-assessment of their cultural sensitivity in caring for minority groups, self-assessment of their perception of cultural competence through repertory grids, group interviews and personal accounts were pivotal in informing the study. Discussion is offered here in respect to how students' views and perceptions might be interpreted when contemplating assessment of cultural competence in undergraduate physiotherapy. However, in order to put this into the context of previous discussions, an evaluation of a framework of assessment within the notion of professionalism is offered.

In considering assessment of cultural competence in the undergraduate curricula, the author maintains the juxtaposition of professionalism with cultural competence and highlights certain factors. Assessment and measures of professionalism are often carried out by peers (Betancourt and Green, 2010; Nofziger et al, 2010) users of the services, the public as well as government and professional bodies. In

a similar way, assessment and measures of cultural competence might also be conducted by peers and professional bodies, but there is limited evidence of the assessment of cultural competence in the literature from client and user perspectives (Gaston-Johansson, 2007). Identified institutional measures designed to nurture professionalism often omit the necessity to make the development of cultural competence an explicit part of the process. It may be the case that professionalism is assumed to embody cultural competence and that it is assessed therein but there is also limited evidence available to support this view or that users of health care services are of the same view.

Feedback from the students in this study indicated that too much time may have been spent on certain topics. Student learning is often driven by assessment methods (Hawkins et al, 2009; Ramsden, 2000). If a subject is deemed to be a low priority, for example by virtue of it lacking direct assessment or language which describes it appropriately, there is a danger that factors such as these may present barriers to learning (Solomon and Geddes, 2000). On the other hand, where students perceive importance of the topic as relevant to clinical practice, it is more likely that they will pursue learning of the topic with greater enthusiasm. Given the recognised influence of assessment on learning, it may not be surprising that these criticisms were made in respect of cultural competence because assessment procedures were more covertly addressed within the curriculum when compared to assessment procedures for other topics. Students may have contemplated that time could have been better spent on other topics which were explicitly and formally assessed.

Hawkins et al (2009) highlights the importance of considering the desired qualities, outcomes and uses when developing assessment programmes in relation to any competency. Identification of these qualities and outcomes in relation to cultural competency require articulation in physiotherapy education. One has to consider whether in an undergraduate physiotherapy curriculum, the acquisition of knowledge, skills and attitudes of cultural competence is an important individual dimension worthy of demarcation or whether it can be continued to be subsumed and assessed under the banner of professionalism. Although Hawkins et al (2009) do not speak of cultural competency, they identify that robust programmes which seek to assess medical professionalism should incorporate mechanisms for considering cultural influences. The views of the undergraduates were that within their undergraduate programme they were deficient in skills they needed to treat individuals from different ethnic backgrounds and this view was still evident in their final year where formal assessment strategies deemed them to be potentially competent professionals at the point of graduation.

As identified, much of the assessment of cultural competence lies outside of the realms of the service users as receivers of services offered by professionals. Students were aware that communication with some service users was sometimes difficult because of language barriers. The role of service users not only in assessing cultural competence but also in assessing professionals continues to be under-utilised or not sought at all, and limited communication compounds this difficulty. Wilkinson et al (2009) identify a number of tools used to assess elements

of professionalism and offer a category of tools which are purported to measure patients' opinions. This list includes a patient assessment questionnaire, simulated patient rating scales and the Royal College of Physicians patient questionnaire but the extent to which these are valid and reliable measures of patients' or users' opinions of professionalism and cultural competency is not clear. Gaining the views of multiple raters and multisource feedback may be seen as a more robust approach to gaining a true reflection of professionalism.

An alternative way of assessing or addressing measures of cultural competence could be considered in the use of outcome measures which are strongly favoured by commissioners of health care. The CSP addresses outcomes as 'the results of health care processes' (Baumberg, 1995). Kendall (1997) relates outcome measures as a measure from one point in time (usually before an intervention) to another point in time. A physical therapy outcome measure is often viewed as a test or scale administered which has been shown to measure accurately a particular attribute and one which is expected to be influenced by intervention' (Cole et al, 1994). If consideration is given to whether cultural competence can be interpreted as an accurate measure of an attribute which can be influenced by intervention, it could be argued that its many attributes make it difficult to assess as one outcome measure, especially by a measure which appears to be positivistic in approach. McDowell and Newell (1996) state that an outcome measure should be standardised, with explicit instructions for its administration and scoring. The measure should be reliable, valid and responsive to the clinical change that occurs over time. Its reliability should be evident in how uniformly the

test can be repeated when administered on more than one occasion or by more than one rater, while its validity should demonstrate the extent to which the measure measures what it intends to measure (Cole et al, 1994). In its responsiveness, it should measure and detect true change in student/patients' status over time (Stratford et al, 1996).

Use of a positivist approach in measuring outcomes in professional outcomes may need to be tempered if outcome measures are considered worthy of application in education, for example in the formulation of appropriate learning outcomes. They would need to be appropriate, convenient for educators and clinicians to use and especially acceptable for students and users of health care services. In order to make rational decisions about the extent to which outcome measures may be applied in the learning and teaching of professionalism, including cultural competence, further investigation is required. Engebretson (2008) recognises the difficulties associated with using outcome measures in this way. Preparing students to work in culturally diverse communities, identification of self-assessed needs and implementing strategies to address them may appear to be examples of measurable outcomes embodied within culturally competent practices. However, ways in which outcome measures for professionalism and cultural competence might be adopted in undergraduate physiotherapy education appear to require more qualitative approaches to measurements since parameters of practice do not fit neatly within quantitative measures. Expressions of professional behaviours occur continuously throughout undergraduate education and thereafter

are highly contextual and depend on the learner's role and location within a continuum of learning (Hawkins et al, 2009).

The extent to which the hidden curriculum influenced developments in the study is unknown. It is commonly perceived to be those unrecognised and unintended aspects of knowledge, values and beliefs that are part of the learning process (Horn, 2003). Within the group interview, students identified the extent to which behaviours outside the formal learning and teaching within the classroom could have influenced their perceptions of cultural competence. They spoke of aspects of self-selection i.e. 'segregation' as to where they sat in the dining room, derogatory comments made by fellow students on campus and compared aspects of their home environments with university life (see Figure 4).

Current research continues to identify the power of the hidden curriculum in learning and suggests that the extent to which it shapes behaviours may be as important as the formal curriculum (Wear and St. Skillicorn, 2009). Given that an important focus in developing professionalism lies in promoting certain types of behaviours, the influence of the hidden curriculum should not be underestimated. Role models, institutional practices, unplanned instruction and social expectations are often cited as important influences. The extent to which lecturers within the undergraduate physiotherapy programme may have been identified as role models and used as a sounding board on which to base students' self-assessment, and the extent to which the culture of the institution influenced engagement with the topic of cultural competence is not known. In recognition of the influence of the

educator, Glicken and Merenstein (2007) identify the crucial importance of enhancing educator professionalism and the powerful effect of the hidden curriculum in the development of professionalism in students. Investigating the culture in which professionalism is taught compared to that which is not taught presents further scope for investigation.

The study raised a number of questions for physiotherapy undergraduate education: What constitutes relevant content in the teaching of cultural competence? What level of student attainment is required? How are levels of students' attainment to be evaluated? How is student attainment to be assessed? Does the subject require specialist knowledge? In seeking to address these questions, it is forwarded that the nature of cultural competence as it pertains to professionalism and continuing professional development in physiotherapy remains inextricably bound with quality of health care and might be dependent on how undergraduate curricula is able to nurture and prepare potential practitioners to develop effectively on each of these parameters.

9.7 Limitations of the study

Akin to other approaches in qualitative research, this mixed methods case study emphasised exploration rather than prescription or prediction and afforded relative freedom to discover and address issues as they arose in the investigations. This in turn could lead to criticism of subjectivity. In addition, the format of this study which commenced within an action research approach and became focused into a mixed methods case could add to these criticisms. In seeking to understand as far as

possible, the perceptions of a small group of subjects, this case study specialised in ‘deep data’, information based on particular contexts whilst attempting to add a sense of realities to the research results as they presented. Although efforts were made to bridge the gap between what may be perceived as abstract research and concrete practice by allowing comparisons of observation first hand as a lecturer, with the qualitative results obtained through different methods, critics may point out that results might not be generalisable and that it is difficult to test for validity. Further criticism could also be levelled at that reliance on few subjects to make cognitive extrapolations to theory and that this runs the risk of inferring too much from what could be seen as circumstance.

The undergraduates and I were the main points of reference and there was limited ‘outsider view’. The problems that this presents may be centred on issues of interpretation and bias. In retrospect, attempts to seek the views of other individuals with whom the subjects came in contact may have been possible and more thought into how this data could have been gathered at the same time as those of the student data might have assisted in countering this view.

The study tracked one cohort of students with one investigator over three years. Even though a number of investigations are presented and wherever possible direct quotes or views were offered, the evidence was presented from the writings and perspective of a single author, therefore a degree of bias could be levelled at the study.

There was an early change in the research design which shifted from an action research approach to a mixed methods case study. Intentions were to have the opportunity to make and instigate changes as necessary in the learning and teaching of the topic. Although permission had been gained to make certain changes, it became apparent that these changes were going to be restricted by the stated learning outcomes of the module. More importantly, potential effects on criteria on which the course had received tripartite validation from the University, the CSP and the HPC were difficult to predict. Greater anticipation of this difficulty could possibly have been made and greater consideration given to a mixed methods case study approach only.

My personal integrity, sensitivity and possible prejudices and/or biases could have given an altered view of reality and could have affected how the investigations were conducted and how the research materials were prepared. Although, reflections and wherever possible, background to the various protocols have been offered, it was the case that the researcher as lecturer-practitioner had a certain degree of authority directly or indirectly over the students and this could raise questions on the implications for the truthfulness of the student responses. In most situations, formal permission was gained from them and they were constantly reminded of the nature of tasks they were undertaking within the whole undergraduate programme, its constituent parts and within the research. Nonetheless, it was still possible that the students felt duty bound by their presence on the course to appear helpful and obliging. Where there were additional interventions which fell outside of the normal programme, as with the

end of year questionnaire, participation came by way of a request and voluntary participation. However, although ethical approval was gained and considerations were followed throughout, since the start of this study applications for ethical approval have become more formal both nationally and locally, and procedures within the University have also changed. The research followed the guidelines which were in place at that time, but it could be argued that the ethical considerations could have been more stringent.

With reference to the terminology used in the research, in the early days of the research the term cultural sensitivity was used interchangeably with the students, for example in QT1 and QT2. The term cultural sensitivity formed the introduction to the research because the students were more familiar with it then the term cultural competence. Criticism could be levelled at the duality of the stance taken thereafter when both terms were used. Similarly, overlapping terminologies were used elsewhere. QT1 and QT2 also included the phrase ‘caring for individuals from minority ethnic backgrounds’ instead of ‘caring for minority groups’. Since permission from co-researchers to use the questionnaire and the research was a direct consequence of the outcomes from earlier work, there was reservation in changing the title.

The theme of cultural competence encompasses more than ethnicity as other investigations in the study have shown and criticism of ethnic bias within the questionnaire may be justified. Similarly, by offering definitions of race and ethnicity within the questionnaires, it could be said that these were influences or

impositions on the students' own perceptions. In their responses to some of the questions, as within some of the literature generally, students used the term 'minority groups' and 'minority ethnic groups' interchangeably, without differentiating them. Although ethnic terminology continues to be problematic at a regional, national and international level as for example in census data collection, further clarity could have been offered at different stages within the study.

Due to the sensitivity of the topic, the interview subjects were chosen based on volunteers; therefore, the responses gained might not been the same for a less enthusiastic group. It was also the case that these students had indicated that they had worked with minority ethnic groups (MEGs). Again, their experiences may have been different to students who had little or no interaction with these groups. Within the process of interviewing, awareness of some of the difficulties and sensitivities surrounding the topic became apparent and interjections occurred, perhaps too frequently on occasions. This was an attempt to prevent too many perceived uncomfortable and pregnant pauses. There is little evidence that this had a negative or on the other hand, a positive effect but without the benefit of videoed evidence and an independent witness, the reader is in a position of having to rely a tape, transcript and the writing presented. The interviewer was also well-known to the students as one of their regular lecturers; therefore, an established relationship could have influenced the responses which they gave, especially in view of the fact they are visibly a member of a minority ethnic group.

Many of the issues which emanated from this study are still current and perhaps still novel i.e. the use of repertory grids in the portrayal of cultural competence in undergraduate physiotherapists. Nonetheless, it is recognised that the impact of altered memory and recall are factors to be considered in reaching conclusions regarding research investigations; therefore, inevitable occasional reliance on recall of events which occurred needs to be considered.

The degree of ownership of the research as expressed by the students was limited. Although the initial idea was triggered from a recognised need in a previous cohort of students and the SHA, opportunity to influence the flow of events were primarily dictated by the written curriculum and secondly by approaches to the research adopted. Students were participants in a process which was embedded in their course and therefore the option for them to opt out of the experience was limited. Offering varying degrees of control to the students along the way in the learning and teaching of the topic of cultural competence may have in part been governed by the role as lecturer, and expectations associated with that role, but considerations regarding imparting a greater sense of shared ownership could have been considered further within strategic developments within the study. Similarly, the influence of outsiders including other lecturing staff reflected normal interactions between staff as they existed at the time of the study with limited opportunity to change planned learning and teaching events. Hindsight suggests that peer appraisal of the processes and outcomes could have been usefully employed and it is suggested that careful consideration is given to seeking this when similar studies are undertaken in the future.

It was apparent that teaching in other parts of the curriculum may have explored aspects of cultural competence and the breadth and depth of this was unknown despite discussions of curriculum content which took place in curriculum development meetings. Lecturers are autonomous practitioners in the classroom and afforded flexibility in learning and teaching strategies adopted. However, further perusal of the content of the teaching with other staff members could have assisted in finding out about potential areas of overlap.

Mixed methods research would seem to have been taking place for many years and some might argue that it has been given the cachet of a new paradigm (Cohen and Manion, 2011). It offered a useful way of investigating the topic in bringing together different approaches at different stages in the research investigations. Yet, critics may still argue that attempting to mix different ontological and epistemological positions of qualitative and qualitative research could be problematic and may dilute the value of each.

A final criticism of the research is that of bias of a sole investigator throughout the life of the study. Even though independent verification of the interpretations of the interview data and thematic content of other narrative were sought on different occasions during the study, perspectives from others may have strengthened findings and widened the lens in viewing and understanding it.

Despite these limitations, the study has identified a number of challenges at national and local levels and puts forward a number of recommendations including areas for further research.

9.8 Reflections

My journey with the students was an enjoyable and satisfying one. I looked at the stated learning outcomes of the programme that by the end of the programme graduate physiotherapists would be able to achieve (see Table 21).

Table 21 Programme learning outcomes

Ability to:
1. Identify the current scope of physiotherapy practice 2. Recognise the importance of confidential and non-discriminatory practice 3. Use theoretical knowledge and practical skills to assess, plan and implement appropriate physiotherapy practice 4. Use powers of analysis and judgement to evaluate outcome measures by a variety of methods 5. Communicate effectively with individuals and groups 6. Discuss current health care and policies 7. Take part in the management of health care, basing decisions within an ethical and professional framework 8. Recognise their own need for continuing professional development, taking part in the dissemination of good practice in health promotion and health care contexts 9. Recognise the need to adapt physiotherapy practice, responding positively to change

I believed this to be true of all those who graduated from the year group. The demands of the programme were not just intellectually demanding but also physically and emotionally challenging for all concerned. Although cultural competence was never written within it per se, instead that ‘all those graduating from the programme would become autonomous individuals motivated to respond

to the needs of individuals and groups within society', I felt that these learning outcomes captured the spirit of its intention. I believe that the input I made, contributed to raising its profile within the curriculum. Potential existed for raising its profile even further within other modules. For example, in year two of the course, one of the identified learning outcomes was to 'discuss the implications of specified conditions for an individual patient, their relative/carers and society'. The level of autonomy afforded lecturers offers opportunity for flexibility and creativity within the classroom as it did for me. However, this is dependent on interest and insight into the topic and choices made by individual lecturers. Similarly, in clinical areas where students were required to develop ability which '[takes] account of psychological, sociological and environmental factors when planning treatment programmes', clinical staff would also need to use similar opportunities. I remain optimistic that cultural competence will continue to feature in undergraduate physiotherapy curricula because there are a number of significant drivers which will continue to challenge its existing profile.

CHAPTER 10 CONCLUSION

Explorations in the literature and the investigation sought to clarify how the topic of cultural competence was perceived generally in health care and more specifically, in undergraduate physiotherapy education. The literature identified perceptions of cultural competence which had wide ranging interpretation by authors and subjects, both nationally and internationally without an overall agreed definition. However, there was sufficient evidence within the literature which offered identifiable scope and common meaning for the term to indicate ways in which its adoption in undergraduate health care education, including physiotherapy, as an approach to addressing inequalities could be utilised practically.

Debates around the epistemological position of cultural competence as a concept remains but explorations within the area of structuralism have begun and are being reiterated by others. Increased clarity in the theoretical and methodological perspectives adopted by many writers is evolving and an interpretative context would seem worthy of further pursuit where mixed methods case study offers scope in which to investigate the dynamics of learning and teaching. It would appear that the learning and teaching of the topic is assuming and developing a recognisable knowledge base. The implications of this for the learning and teaching of the topic places it within a recognisable pedagogy from which future curricula developments may be explored and expanded.

The case study of undergraduate physiotherapy students offered a unique view of student perception of cultural competence in a three year programme of study. In comparison to other subjects within the literature, results from this investigation were not markedly dissimilar to experiences expressed by other students in other professions and in many ways confirmed the need for raising a national consensus on how the subject is taught and assessed. Authors have investigated how cultural competence might present and how it might be developed but this is the only study which has offered insight into how the topic is perceived by undergraduate physiotherapists. They indicate that there is a striking difference in students' self-assessment of their ability to care for minority ethnic groups compared to a white majority population, a lack of resources to support them and a need to experience varying cultures of the populations with whom they work. The NHS workforce is a major employer and although registered physiotherapists form a relatively minor part compared to nurses and doctors, all of the professions are seeking similar clarification of the topic. The teaching of the topic in undergraduate curricula lacks cohesion, clarity and appropriateness in developing practical skills in this area. The international picture is similar, although the US in particular has a relatively long track record in dealing with the topic as an important issue within health care education and patient care. Nonetheless, overall, there still remain major omissions regarding successful outcome measures from patients' perspectives.

Factors which are said to move physical therapy students to deep and strategic approaches to learning include relevance and context of learning, appropriate sequencing of learning, assessment methods, connections between new learning

and previous learning and discussion with classmates (Sellbeim, 2003). The topic of cultural competence was never overtly expressed within the written curriculum to enable students to make the necessary connections between new learning and previous learning, neither was it expressed overtly in assessment. Yet, it could be argued that in the end of course questionnaire, there was evidence that students had developed aspects of 'deep and strategic learning' of the topic within the curriculum. The presumption was that this may have been strongly influenced by the actions within the investigation but it was difficult to gather experiences of all of the students in relation to the topic in order to form robust conclusions. It could be assumed that the informal and the unwritten or hidden curriculum had also been powerful influences on student learning and that these played their part in informing their development into the competent practitioners they were deemed to have become in passing the course.

Reliance on the informal, unwritten or hidden curricula to inform learning can be unpredictable in the outcomes produced. The hidden curriculum is said to relate to structures which influence the learning process and professional norms while the informal curriculum relates to students' interactions and immersion with various groups such as patients, family members and their teachers and organisational staff (Karnieli-Miller et al, 2010). Where there is a lack structure such as exists within the informal curriculum with learners gaining exposure to different levels of experience, the learning experience could become variable and at times even contradictory making it difficult to assess the quality of learning and teaching. Therefore, in leaving the learning and teaching of what is deemed to be an

important topic within curricula of undergraduate physiotherapists to chance, renders a level of inequity and variability in the learning outcomes which I would argue is undesirable in a professional programme.

Lockyer (2010) reminds us that attention is also required to fill the gaps between formal and tacit or implicit knowledge. The students in this study presented with varying levels of ability and their needs were also variable in studying the topic of cultural competence. This was made clear in their responses within the investigations. The framework for the study of structured knowledge within academic programmes is often identified in relevant course documents and/or handbooks. On the other hand, tacit knowledge which is information one is assumed to know because it stems from, for example, past experiences and through social networks, is much less apparent. Therefore frustrations and errors are not uncommon when students find themselves in situations where feedback suggests that they may be underperforming or are becoming unsure because assumptions made about their ability leaves them feeling under-prepared in certain contexts. Within the interviews and following visits to interact with minority groups, students reported their need for increased confidence, therefore addressing areas of tacit knowledge in the learning and teaching of cultural competence requires further attention.

From a national and governmental perspective, it has been acknowledged that the range of knowledge, skills and attitudes of the AHPs (where physiotherapists form the largest group) are not widely understood and this has been identified in the

government publication ‘A High Quality Workforce: NHS Next Stage review’ (DH, 2008a). The DH proposed that a web-based framework of competences should be developed by Skills for Health (SfH) as part of the UK-wide ‘Modernising allied health professions careers: a competence-based framework’ (DH, 2008b) as a possible solution, but cultural competence has not been a feature. Part of the SfH agenda is the development of frameworks around certain patient groups such as children, older adults and individuals with long-term chronic ill-health and the competences under development are generic, directed at personal career planning, workforce planning and the commissioning of education and training. The idea behind this development is that learning opportunities and programmes for the AHPs should be linked to specific roles in the workforce and that this will be linked to commissioning of health care. It would seem that an opportunity to include cultural competence as a generic skill in this context has been missed since it does not feature. Given that collection of data based on the patient experience will be mandatory (DH, 2008b), not gaining patient perspectives of culturally competent care could be a major omission when assessing quality of care.

The pervading political and health care climate within the UK identifies opportunities and challenges for developing a curriculum that is truly appropriate to patient care with the potential for international exchange in an ever increasing global forum. Although challenges continue to present in identifying the basic principles and premises on which the concept of cultural competence rests,

common strands and frameworks of understanding already exist and these could be adopted to influence its learning and teaching within the UK.

Guidance on how the topic of cultural competence is to be taught in undergraduate health care education, especially in physiotherapy, requires much needed research. However, in concluding this study, I forward the view that if cultural competence as a concept is to be successfully integrated into physiotherapy education and practice, certain essential principles will need to be adopted. These are the use of a commonly held and understood definition on which to develop learning and teaching on the topic in undergraduate health care education within the UK, and for cultural competence to be identified in curricula as a fundamental part of the required competencies of professional health care practice. If equality of health care is seen as an integral goal of the NHS, where due consideration of the context of care delivery is viewed as implicit, then cultural competence should be deemed to be an integral part of that context and within it, the development of professionalism.

10.1 Contribution, recommendations and future research

This research is the first to explore the perception of cultural competence of students within an undergraduate physiotherapy programme within the UK. It was distinctive in adopting a mixed methods research case study which utilised qualitative and quantitative approaches in seeking to explore and answer identified questions in undergraduate health care education in a pragmatic way. It identified that students' perceptions of cultural competence were generally consistent with

perceptions of others found in the literature. However, it also confirmed that there is a lack of consensus in defining the term and that its learning and teaching remains covert within undergraduate physiotherapy education generally.

The study was also unique in adopting use of repertory grids to investigate students' perceptions of cultural competence through their formulation constructs. The grids enabled them to make their constructs overt. They showed clear differentiation between behaviours in cultural competence and those associated with clinical competence. Despite citing lack of confidence in cultural competence, students' self-assessed rating of their cultural competence was rated consistently higher than their clinical competence. Based on previous research, it confirms the notion the students may be 'unconsciously incompetent'. This has potential implications for the learning and teaching of the topic, and requires further research

Contribution to existing knowledge also arose out of the proposition that exploration of students' perceptions of cultural competence held implications for learning and teaching of the topic, and this was confirmed. The research demonstrated that identification of these perceptions could be incorporated into established learning and teaching strategies which seek to develop independent and reflective practitioners.

Similarly, the proposition that a programme of learning and teaching of cultural competence which could be developed based on exploratory data of student

perception was confirmed. Learning and teaching centred on students' identification of their own needs enhanced relevance and engagement of their experience within the programme However, the study also highlighted that a significant lack of resources could have hampered their ability in gaining confidence in this area of practice.

The adoption of Erzberger's and Kelle's (2003) approach in triangulating the data assisted in making explicit the processes surrounding the propositions and their relationship to the empirical base which allowed for the adoption of qualitative and quantitative approaches within the study. It facilitated the formulation of theory through evaluation of component parts of the triangle.

Based on this research, it is suggested that undergraduate courses make explicit learning outcomes associated with the development of cultural competence within their programmes. They should also consider making explicit the associated topics, for example those suggested within this research and the literature and utilise established learning and teaching strategies which are based on students' identified developmental needs. Institutions of higher education are often well situated to develop independent and reflective practitioners and have established strategies in which the learning and teaching of cultural competence can be usefully embedded. In identifying student learning needs, established channels such as questionnaire and interview was shown to be useful.

Areas of clinical practice and student placements remained relatively unexplored. Given that approximate 1000 hours or approximately one third of the course takes place away from the academic base of the students, careful attention is required to address learning outcomes in relation to the topic in these locations. Students also stated that they placed heavy reliance on their clinical educators to assist in areas of intercultural communication, yet there is some doubt regarding the extent to which clinicians are prepared to explore student development in this area. A few studies were shown to have investigated the relationship of cultural competence to professionalism and the part played by clinicians as role models in developing this, but this relationship requires further research within a physiotherapist context.

It is recommended that:

- Cultural competence is introduced and made explicit in undergraduate physiotherapy programmes to assist in the evaluation of students' ability to deliver effective health care for diverse populations.
- Undergraduate programmes of learning and teaching in cultural competence are based on the students' need and perceptions of cultural competence.
- Topics for inclusion in a programme of cultural competence are supported by the literature and research.
- Strategies for its learning and teaching are embedded in established approaches aimed at developing adult learners in becoming independent reflective practitioners

- Further research is adopted to explore the relationship between cultural competence and clinical competence, including further use of repertory grids to assist in elucidating these constructs.
- Further research is conducted to explore the relationship of cultural competence to professionalism and the role of clinicians.
- Mixed methods research and the triangulation metaphor are explored further as a means of investigating pragmatic and complex research questions within physiotherapy education.

While the UK population and users of health care services continue to grow increasingly diverse, the cultural competence of physiotherapists within the UK remains generally unknown. The question remains whether physiotherapists are equipped to deliver effective intercultural and transcultural healthcare. The desire to answer this and to make it explicit rests with individual practitioners and individuals at varying operational and strategic levels within departments and institutions. It includes developers of curriculum who are charged with developing the healthcare professionals of tomorrow. It is hoped that this study helps to fuel that desire to take on the challenges this study has raised.

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APPENDIX 1

Submission to Curriculum Development Committee

UNIVERSITY OF BIRMINGHAM
SCHOOL OF HEALTH SCIENCES – PHYSIOTHERAPY
DEVELOPMENTS IN THE TEACHING AND LEARNING OF CULTURAL STUDIES

A project to develop and evaluate educational and training programmes to increase the cultural sensitivity of health care professionals to promote positive health outcomes was carried out by the School of Health Sciences. This developed from a project seeking to provide culturally competent services to patients within the University Hospital Birmingham NHS Trust.

The preliminary results of a recent investigation within the School of Health Sciences suggested that there was a need to 'move the curriculum forward on the issue of cultural sensitivity'. This has prompted a re-examination of how the physiotherapy undergraduate programme addresses cultural studies.

It was apparent from the results of the project that within the first year of the course students felt they had little input and little awareness of cultural and multicultural issues. Although the second and third year students were perhaps a little more aware, they felt at times ill-equipped to deal with some of the issues which arose within the clinical environment. These feelings were also reflected by clinicians.

In response to the findings of the project, the School has developed some aims to address cultural sensitivity within the curricula (see below).

In order to address some of the concerns highlighted within the physiotherapy curriculum, changes within the Illness, Behaviour and Research module has been made to introduce the topic of 'culture' and to facilitate discussion. Clinical Studies within the second year has given greater emphasis to the development of cultural competence within the programme. Following a study of culture, race, ethnicity, minority groups and 'multicultural communication', students are currently exploring the different lifestyles of the minority groups in Birmingham by interacting with the local communities. They will then share this information with the rest of the year group in the form of presentations. The main aim of this activity is to increase the awareness of students on the different cultural groups in Birmingham. Additionally, the information gleaned by the students will contribute to a resource file on 'Cultural groups in Birmingham' and will provide a reference source for students and staff within the School. It is hoped that this will form a small but significant contribution to the development of resources within the School for the teaching and learning of cultural issues.

The module will also give students the opportunity to examine culture/cultural diversity, race/racism and the contribution of the CSP in the management of equal opportunity and minority groups.

Aims to develop cultural sensitivity within the curriculum

To:

1. Ensure that the topic of culture and multiculturalism is not just an 'add-on' but becomes mainstream within the curricula.
2. Monitor how the issues surrounding culture is managed within the School.
3. Explore with each member of staff how the topic of culture could become 'mainstreamed' within their subject area.
4. Organise 'training' sessions for staff including the use of external individuals from minority groups as appropriate.
5. Provide mixed discussion forums for staff and students with at least two members of a minority group present.

6. Identify the learning and teaching resources used within the School and make these known to all staff and students.
7. Ensure that all staff receiving students on electives, especially overseas staff, are aware of the School and the University's stance on issues of equality of opportunity.
8. Investigate including a paragraph on 'appreciating diversity and cultural differences' within the Subject Handbooks.
9. Include information on cultural awareness, and equal opportunity from the RCN and the CSP and the support available from these institutions for students within the induction week or near the start of the programmes.
10. Identify an individual lecturer or a small group of lecturers who will take responsibility for coordinating and giving advice on this aspect of the curriculum.

APPENDIX 2

Approval letter for use of questionnaire

APPENDIX 3

Excerpt from letter to SHA Regional Educational Lead

APPENDIX 4

Three year plan of BSc (Hons) in Physiotherapy programme

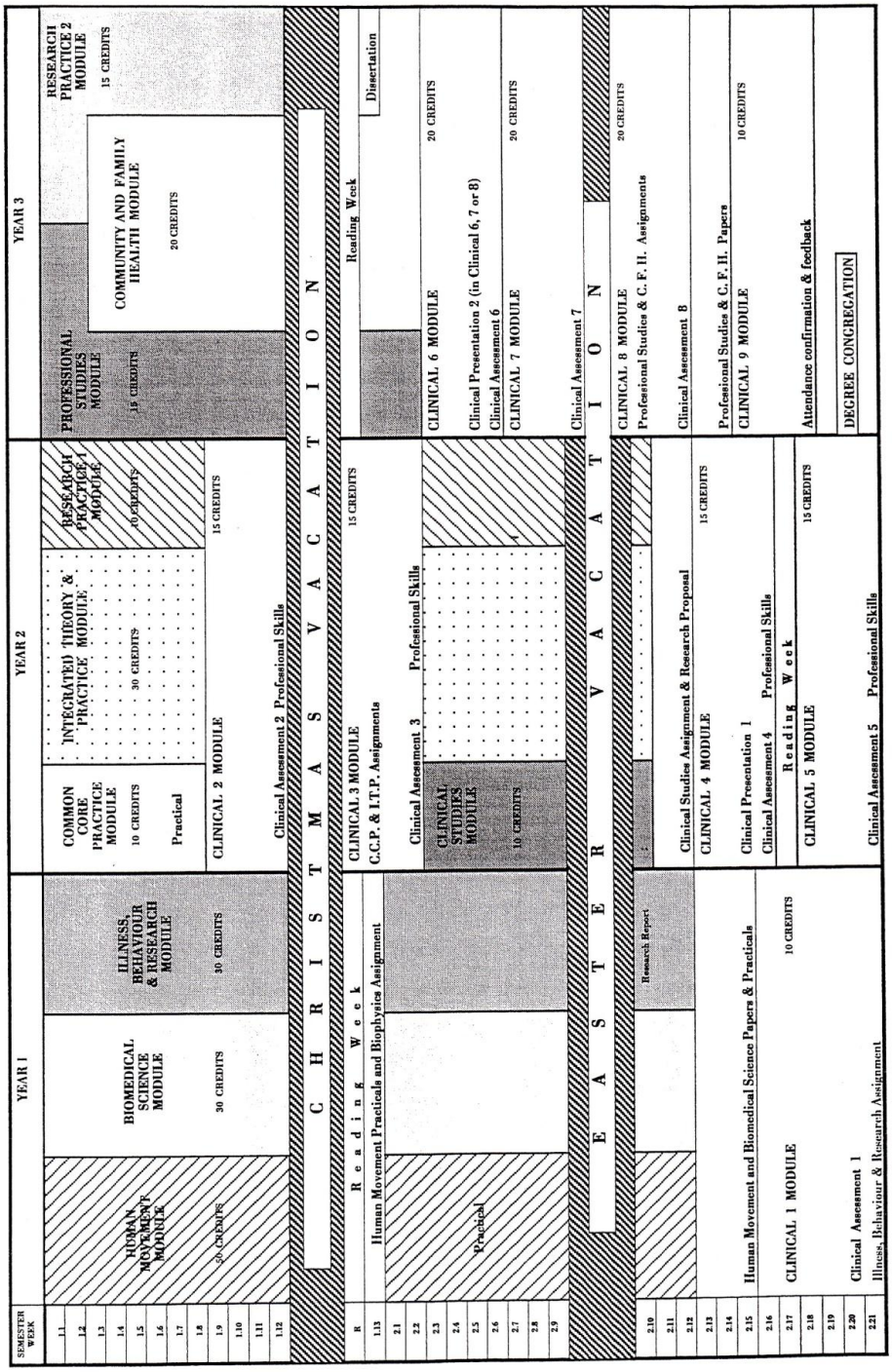


Figure 2 Three Year Plan of B.Sc (Hons) in Physiotherapy Programme

APPENDIX 5

Questionnaire T1

CARING FOR PEOPLE FROM MINORITY ETHNIC GROUPS

STUDENT QUESTIONNAIRE

This questionnaire aims to explore issues in work about caring for people from minority ethnic groups.

You are asked you to respond to a number of questions.

Please tick responses as appropriate and comment wherever requested.

Thank you for your help in completing this questionnaire

Please return via internal postal systems in the envelope provided to:

School of Health Sciences (Nursing)

Xxxxxxxxxxxxxxxx
Xxxxxxxxxxxxxx

Definitions

To ensure that all participants understand some of the terminology used in this questionnaire we have listed some working definitions of ethnicity, race and culture below. Please refer to these if you have any problems with specific questions asked.

Ethnicity

> 'The sense of identity which derives from membership of a group linked by different combinations of shared cultural characteristics, such as religion, language, history or geographical location' (The Open University 1993).

Race

> 'One of the divisions of humankind as differentiated by physical characteristics' (Senior and Bhopal, 1994).

or

> 'Any of the great divisions of mankind with certain inherited physical characteristics in common e.g. colour of skin and hair' (Oxford Dictionary, 1990).

Culture

> 'A combination of historical forces and environmental factors in different geographical locations' e.g. language, religion and artistic achievements' (Baxter, 1997).

or

Ethnic Groups

> The customs and civilisation of a particular people or group. (Oxford Dictionary, 1990)

SECTION 1 BIOGRAPHICAL INFORMATION

Please indicate your professional discipline

Nursing □ Physiotherapy □

Occupational therapy □ Medicine □

Speech therapy □ Other – please specify……..

1.3. Year of study

1st year □ 2nd year □ 3rd □ 4th □

1.4. Your age range:

Under 18□ 18-25□ 26-35□ 36-45□

1.5. Your Gender:

Male □ Female □

SECTION 2 DEFINING ETHNIC GROUPS

2.1 If you were asked to describe your own ethnicity how would you do so? (e.g. White, Irish, Asian etc.)

2.2 The following categories are commonly used to ask people to indicate their ethnicity. Please tick the box you feel describes the ethnic group to which you belong:

White	☐	Black-Caribbean	☐
Black-African	☐	Black Other	☐
Indian	☐	Asian	☐
Bangladeshi	☐	Pakistani	☐
Chinese	☐	Irish	☐
Jewish	☐		

Other Ethnic Group (please specify)……

2.3 In the context of your own definition in question 2.1 do you have views on the above categories – if yes, please comment below. If no please go to the next question.

2.4 Approximately, what percentage of your current professional activity would you say involves working with people from minority ethnic groups?

0-10% □ 11-20%□ 21-30%□ 31-40%□ 41-50%□ Over 50%□

2.5. Please mark a vertical line through the scale below to indicate:

a) How able do you feel you are in meeting the needs of patients from minority ethnic groups?

Not Able | Completely Able

b) How able do you feel you are in meeting the needs of people from the majority (white) population?

Not Able | Completely Able

2.6. Drawing on your experience, what common problems do **you** face, if any, when dealing with issues related to caring for people from minority ethnic groups ?

2.7 Are you aware of any issues attributable to ethnic origin (such as diet, religious practices) where **colleagues** have had particular problems?

YES □ NO □

If yes, please state the issue/s

2.8. What do you think helps patients from different minority ethnic backgrounds receive the best from the NHS?

2.9. What do you feel creates barriers for patients from different minority ethnic backgrounds in receiving the best from the NHS?

2.10 Within the NHS a number of issues commonly cause concern for some people from minority ethnic groups. These include language, religion and culture. Please indicate below how satisfied you are with the education system/s designed to help in the understanding of these issues in both academic and clinical settings?

(A) University Setting (Please tick the appropriate box)

Topic	Very Satisfied	Satisfied	Fairly Satisfied	Not Satisfied	Not Addressed
Language					
Religion					
Culture					

(B) Clinical Setting (Please tick the appropriate box)

Topic	Very Satisfied	Satisfied	Fairly Satisfied	Not Satisfied	Not Addressed
Language					
Religion					
Culture					

2.11 Approximately how many lectures have you attended aimed specifically at issues related to working with people from minority ethnic groups?

None □ 1-5 □ 6-10□ 11-15□ 16-20 □

If you can recall them please give the title of any sessions on this topic

-
-
-
-
-

Please indicate how useful you found these lectures.

Very Useful□ Useful□ Not at all useful□

Please comment:

2.12. How do you think training programmes could further prepare students

to meet the health care needs of patients/clients from minority ethnic groups?

2.13. On the relevant scale below mark a vertical line to indicate your level of awareness of the cultural practices of minority ethnic groups in Birmingham.

A) African	No Awareness		Complete Awareness
B) Caribbean	No Awareness		Complete Awareness
C) Bangladeshi	No Awareness		Complete Awareness
D) Indian	No Awareness		Complete Awareness
E) Pakistani	No Awareness		Complete Awareness
F)Chinese	No Awareness		Complete Awareness
G) Jewish	No Awareness		Complete Awareness
H) Irish	No Awareness		Complete Awareness

Other	No		Complete
(Please Specify)	Awareness		Awareness

2.14. Are you aware of any differences in disease prevalence/incidence/mortality between different ethnic groups?

i) Disease prevalence YES□ NO□ NOT SURE□

ii) Disease incidence YES□ NO□ NOT SURE□

iii) Disease mortality YES□ NO□ NOT SURE□

If yes please elaborate:

2.15. Are you aware of the availability of any specific educational resources to help staff in clinical areas with issues on cultural practices?

YES□ NO□

If your answer is no, please go to the next question.

If your answer is yes, please list the resources.

i

ii

iii

iv

2.16. There is one more section on this questionnaire overleaf. If you wish to make any general comments in relation to the topics raised in the questionnaire overall please do so here.

General comments.

APPENDIX 6

Plan of Illness, Behaviour and Research module – excerpt from Programme Handbook

14. show awareness of sources of current work and research in relevant areas, being prepared to critically appraise and disseminate information for the benefit of peers.

Teaching and Learning Strategy

This module will be presented in three strands: research method, behavioural science and clinical science (Figure 8). Correlative Seminars will foster understanding of the integrated nature of physiotherapy studies and lay the foundation for the first clinical module, facilitating transfer of learning in subsequent clinical education blocks. An underpinning concept will be critical appraisal. Presentation methods will include lectures, tutorials, practicals and guided study. Learning opportunities will include discussions with third year students as they conduct research.

	Week	Research Method	Behavioural Science	Clinical Science	
SEMESTER 1	1	Library & Computing Approaches			CORRELATIVE SEMINARS
	5	to research	Introduction to learning	Introduction to disease	
	7	Measurement	Social Psychology	Rheumatology	
	9	Data collection	Communication 1		
	11			Trauma 1	
	Reading				
	13	(Assessment Week)			
SEMESTER 2	1	Descriptive Statistics	Personality, motivation		
	4	Reliability, validity	Illness, disability, coping	Trauma 2	
	5	& control			
	7	Inferential Testing		Medical Respiratory	
	10	Research Assignment	Communication 2	Assessment	
			Culture	of	
	12			Patients	

Figure 8 Plan of the Illness, Behaviour and Research Module

47

APPENDIX 7

Consent request to complete Questionnaire T2

8th June 2001

Dear Second Year

I would be most grateful if you could help me by filling out the enclosed questionnaire which is similar to the one you completed in the first year. It will of course remain anonymous (unless you wish to identify yourself!). Your visiting tutor from the University has kindly offered to return it to the School for me. If you could find the time to complete it while they are visiting you could return it to them on the same day. Alternatively, please could you return it to them on the second visit. If you decide to take this second option, please do not forget to have the questionnaire with you on the day of their next visit! The questionnaire should take approximately 10 minutes depending on how much you wish to write.

Thank you very much for your help.

Mel Stewart

Lecturer

APPENDIX 8

Consent to participate in group interview

SCHOOL OF HEALTH SCIENCES – PHYSIOTHERAPY

CLINICAL ONE MODULE

July 10th 2000

To the Interview Participants

LETTER OF AGREEMENT TO PARTICIPATE

Thank you for agreeing to take part in this interview and to have it recorded. Although these discussion form part of the Clinical One Module, I am hoping that the information gained today will also make an important contribution to the study of cultural competence which I am investigating as part of my Ph.D. The information you offer will have no bearing on the assessments of your BSc (Hons) in Physiotherapy programme, and will remain completely confidential. If you require further clarification on any issue related to the study please do not hesitate to ask.

Please sign this letter of agreement below.

Signature

.....

THANK YOU VERY MUCH

APPENDIX 9

Excerpts from interview transcript

[X] denotes where cuts have taken place

What skills do you think a physiotherapist requires to become culturally competent? I chose you because you said you've actually been in diverse groups, it's not an easy question, but culturally competent, what skills do you think you need, and this is just for everyone really, urm. Did you meet patients that were challenging out there? Yeah go on.

I think maybe you need a sort of understanding of their, of their culture to start with, urm but being able to talk to them about that can be difficult, if there is a language barrier there, yeah.

Did you come across language barriers? Yes, What sort of languages did you …

Chinese, oh right, where was that?

Outpatients in X.

Okay is there a large Chinese community in Sutton?

Urm, no we only came across about three patients, but the one in particular, had a lot of pain and she couldn't describe the types of pain when she cried and when she didn't, it was terrible, so…

What other patients did we….?

I had Punjabi and a Chinese lady as well but her English was good enough to get the basics across, but when it came to more details you needed you could not get them from her.

So, was there any help available?

Relatives…

You used relatives…

Normally her husband came with her, but he couldn't park the car so in this one instance she was completely on her own. We had a translator for one session, but it was not particularly helpful because this man had a stroke and they thought he

had other problems as well so he really did not understand the question which really did not help at all.

Oh dear,

[X]

But erm, but it was very strange to think, cause he was convinced that it was the will of Allah that he was ill and therefore it was the will of Allah that was going to make him better, and whether he complied with our treatment or not was not going to make any difference. So it was quite hard to think that if you could just do this then it would help you, but he did not seem interested. …

But you say understanding their culture, what is it that you need to know do you think, do you think you know what you should or knowledge you need to be able to work…?

Sorry, I know of the one Urdu lady that we saw, urm I was on a women's health placement, which is quite intimate, quite personal, and err her husband was there, she did not want the interpreter there, cause we would have preferred to have the interpreter with us, because he was answering her questions, and you did not know what questions you could ask without, you know because a lot of the things we wanted to know would not have been appropriate, and my adjudicator was like, well you know she wrote some things down on a piece of paper and gave them to her, but she said if she wasn't going to have the female interpreter, there was nothing more we could do for her, because the questions he would not answer, the husband would not answer a couple of the questions we asked her, which were quite important in our assessment of her, anyway we couldn't visually assess her because obviously err that was not appropriate either, so it was difficult to know what to do so... Another lady we had was a Kosovan refugee….

[.X.]

Do you think you have the skills?

Um no no… I always used to think, you know before I went out that language barriers weren't going to be that much of a problem and it would suggest that with all these things that you could get round to it and in terms about treatment that there was not that much of a problem, but I just felt incompetent, because there was this 99 year old lady, and she wasn't in pain, but we just tried to stand her up but she was so depressed she wouldn't stand up, but she sat down and she was looking at me,my friend X was there as well, but she was looking at me, held my hand and was just speaking and I didn't have a clue what she was saying. And it's

not like…. I wasn't trying to get anything across to her, so I couldn't use any visual aids or anything like that to get across my point, it was just her talking to me and she was just waiting for a response, and just looking at me, and she wasn't getting distressed or anxious or anything, but I just felt really like, I haven't got a clue what to do, and didn't really know how to handle it, so…..

Didn't the clinical educator help?

Yeah he just sort of comforted her and said to me, look don't worry, like I said it was not part of our assessment it was, and she wasn't in pain or anything. And then he just said to her, I don't know if she understood …..

I was going to say, do you think he communicated any better?

I don't know but could just handle it better. He just, I don't know whether he had seen her before but he'd obviously been in a situation where patients have tried to communicate and he just sort of urm put his hand on hers and said we will see you later, and I think its just cause he had dealt with it before, but I was just stumped as to whether I should just try and get anything out of her or didn't know what to do…

This isn't one of the questions I've got down here but how do you think the school could prepare you better to deal with this?

[X]

I know in the department I was working in, because this was obviously a big problem for them, they had like leaflets that they had written up in Urdu and Punjabi, that she said and my clinical educator said that if you encounter a patient that doesn't talk English, that a lot of the time all we can do is leave them this leaflet, they can read it through and work out for themselves what they need to self-treat basically.

And then again you see a lot of migrant groups aren't literate, yeah well so the leaflets go so far and then, you know they don't have a place anymore, so we really do have to think about the strategies that we need to use, is there anything else?

I think my placement was different cause I was at Landrover, so urm there wasn't any interpreter, (in Solihull?) in Solihull yeah, so there wasn't any interpreters, none of my clinical educators spoke any other languages, and urm I was left with a gentlemen who I don't know what language he spoke, but he did have limited English, but erm I was left to try and teach him better posture, and I just felt like I was banging my head against a brick wall, he just wasn't understanding what I was saying, and even when I tried to show him, he just didn't seem interested in

what I was trying to tell him. And he was booked in for an appointment a couple of days later, and he didn't turn up so….

So you think again it may have an effect on, you know the patients don't feel as though they are getting a good deal, whatever group they are from, they are not going to be too motivated to come back are they, urm and I think that's hard, hard on us and hard on them. Yeah because as you say you haven't got all the strategies that we can use….

We used a doctor at one point to translate, cause it was an ITU so obviously he's on a lot of personal use and drugs anyway, and it turns out as I was treating my HG in other wards he could talk English very well, it just as obviously when you are on drugs and if its his first language cause he's Asian, and also knowing what to call them, because we were calling him, it was Mohammed something, and then I didn't know what to call him, we were calling him by the name but…..

[X]

How much interaction did you have with black and minority ethnic groups before you started your undergraduate course?

Lots….Not very ur very……some…..

Right so tell us a little bit from your background a little bit, so where when you say you did not have much interactions.. go on .. school?

Urrr..yeh I went to an all-girls private school….

Where was that?

In X, which isn't, there are predominantly Asian areas around Wakefield but they tend to be poorer areas. I mean there were Asian and black people there, but they were in the minority, urm so I had friends that were Asian and black but they weren't like some of the schools that I've seen on my way to placement where they you just think, ah that's so weird because the white children were in the minority, and it was. the other way round.

But generally …

But they were all anglicised, yeh… My friends were kind of anglicised so they weren't…

You didn't see as much of their culture as ….

No, yeh….

I can remember erm when I left home and went away to University, the first time I heard, and it was mainly the boys using language that I was, I was shocked.

Go on. I'm not easily shocked …

The way they were describing them, I have never heard them be so derogatory, anybody be so derogatory…..

These were boys where?

At University.

Right. Describing ethnic groups?

Yes, yeh.

You don't want to describe the terms that they use, because it's not the sort of terms you'd use…

Where I, where I was from, you didn't hear it, and I don't know if it was where they were from in the country. I think they were used to having a lot of immigrant groups around, and it was it was shocking.

Do you think there is a difference, you say it was from where you were in the country, for you there is more mixing of the groups?

Definitely…

Does it lead to more anti…..practice?

No…

Go on…

I mean in our school I think we had…

And where was your school?

In surrey, in Guildford, and urm, I mean in Guildford there was more ethnic minorities …

I've been to Guildford….

But in the school I was at in ((X)), I mean it's a normal state school but I think there was one brother and sister that were coloured and a few Asians, but that was it, and the only people that I met that were not black necessarily, but from different countries like Albania as that's where I went to work as a waitress…

[X]

Yeah, ethnic minorities, but there were, we had huge issues at college and that the area where I live and that's what its like, that's what I have been used to mixing with, but at college, there for some unknown reason there was a huge issue at college because we had different social areas, and

Social areas?

Yeah and we had like a canteen, a common room and like other areas, you know just sort of socialising and for years at the college its been white people go and sit in one area, urm Asian people sit in another area, black people sit somewhere else, and you see little groupings and its really strange, because everybody is friends but if, I would feel uncomfortable going into the canteen, and feeling in the minority then even though in sort of lessons and stuff it was all mixed, when you got into sort of social areas, and it wasn't hostile, it was just the way it happened… it was very strange.

Self-selecting perhaps, people just identified with people who they felt comfortable with perhaps…

Yeah because they know their background perhaps so they gonna mix with people…

[X]

What about the rest of you, backgrounds?

Urm well I'm like basically the same as X, basically you were really in the minority if you were like an ethnic minority group, but yes it was quite different coming here. Like urm I thought it was quite strange, like one of my flat mates, she was Asian and she got on like perfectly well with all of us, but she always whenever she went out at night, she was always going out with her own Asian relations, you really notice that, they really do stick together and they do everything…

That's almost, I mean that's almost I mean sounds really silly, but like in nature isn't it you mix with your own kind its your natural instinct, and I don't think well I certainly don't, I can't speak for everyone else, but you don't do it consciously, I don't think you do it consciously, I think…...

[X] **have you ever encountered any problems in treating black and minority ethnic patients**, you have highlighted some about the language but are there any others, any problems that you felt… go on X.

Erm there was an Indian man that I was treating for a knee problem and he came in my first week and when I was mostly just observing him and the clinical

educators kind of seeing him with a knee problem, we did all the assessment and stuff, and worked out what it was and what we thought it was, and then he'd come in a couple of days later, for the treatment and in the first week it was fine but he came in every two days for the entire four week period, complaining of swelling on his knee when there wasn't any. Erm the pain kind of went, it was a medial collateral ligament problem, the pain kind of erm went from there to half way up the inside of his thigh but, but none of the resisted ... in any muscle damage at all, and erm he just like, he was trying I think, it was just a bit political because obviously at Landrover people try and get off their jobs and they want compensation and stuff and I think it was more to do with that, but he was, it was just like all the swelling still there every time he came in and it was there, wasn't at all… there was no swelling…

Would you say that was peculiar to him as a minority ethnic person or just any individual at Landrover who might, seeking compensation?

It was more noticeable with him, cause there were, you can tell when there's someone trying, you can tell when someone was trying to claim compensation, but it was definitely more noticeable with him, and the clinical educator said as well that it was just there was nothing wrong with him at all, in the end he may have had a problem to start with but he was just trying to pull it out….

[X]

Had one lady who had just had a hysterectomy and we say therefore they're not allowed to do any more heavy lifting, anything heavier than a kettle of water for six weeks, and went and told this lady, that's impossible I can't, I'm expected to do everything in the house, erm which is their culture, I think that the woman runs the house and does everything like all the cleaning, the cooking, all the shopping everything, and you know we said have you got any children that could help. Like no they're all boys…

And they're not allowed to help….

And they don't help, so we literally couldn't, she wouldn't have the six weeks, erm what we call rest you know not lifting anything. You know she was gonna literally go home four days after her operation and go straight back into ... and I think that was definitely ....

How are we going to sort problems like that out, any ideas?

Keep them as inpatients…

I don't think Mr Blair is going to buy that one somehow…

I don't think you can, can you, because it's a patients right to do what they want….

Patients do have a right but here you have a conflict don't you. You have what you believe to be detrimental to her health, and also respect for her culture, what are we going to do?

[X]

What concerns do you have and perhaps individually here in treating people from ethnic minority groups, what concerns do you have personally?

There's the whole thing about asking them to undress. We had an Asian lady who came with her husband and she had been referred originally to a male physio but on the first appointment she said no, she needed a female which is fine and so she was referred to my clinical educator but, when I saw her she was only with her husband but apparently one time when the clinical educator had been with her on her own, she doesn't speak any English, her husband was translating, but when she was on her own it was, she was less inhibited to say you know when it hurt her cause it was a back problem and we needed to know when, which, when you're palpating when it hurts, and when her husband was there she would just say something and urm in their own language and then he would just say something back, but you'd get much less out of it than what, when it was actually her saying it to the clinical educator even if…

Even though her language was limited…?

Yeah, even though there was a language problem…

Okay so the undressing was a bit…?

And she seemed to be a bit inhibited when her husband was there, for the undressing it was for her neck and she didn't take it off, she just, it was just quite loose clothing just to slip down the back…

So did you manage to sort out with her adequate undressing?

Yes that was okay, I think it might have been a problem if she had had to undress further but we didn't need her to because it was her neck.

Do you think she would have been happy being it just females to undress, if it was explained to her…

I don't know, I don't, I think her husband would have been happier, but she wouldn't have minded, but I don't think her husband would have liked it…

He doesn't have to be there does he…

No, no…

Right…

I think erm women when it's in their own culture at home, it's women that all those inhibitions sort of go over, because we had one lady on the obstetrics ward who every time she knocked on the door she had to say, male or female just so she could put a scarf on…

[X]

Something that came up on a placement was erm, that my clinical educator spoke about was that erm ethnic minorities in general tend to have lower pain thresholds than Caucasians or…

I smile because I hear this one often…

Yeah and erm, but it did seem to be kind of true, its hard when you try and ask them to do movements for you, cause although obviously the pain is real to them and it doesn't, it shouldn't really matter because he's still trying, if it's immense pain that they say to start off with you can get it better whatever, but they are less likely they don't want to move as far...its just the slightest twinge of pain…

I …

Go on…

I didn't see any of that, I have to say all the ethnic minorities I saw there was no difference at all…

No, no…

Err in fact the Chinese lady I thought was really brave even more so than some of the white ladies that screamed every time their backs were touched, Chinese lady you could tell she was in a hell of a lot of pain, cause her eyes were watering but she was determined not to show it, especially when her husband was there, so I don't know….it must be just situations…

I've forgotten your name…..

…X

Did you come across any of this X?

Erm yeah, the pain thing was definitely, there's one it's definitely a culture thing, cause all Asian people that I saw were, made so much more of a big deal about it, and if it hurt and they weren't doing anything and that was it. There was no discussion there was no nothing, it was like, it was really hard to think if he could just do it then it would be great…

It's not just Asian people…

It was males… it is…

But perhaps that's all to do with their culture than erm, I don't want to say that women run round after them, but if they don't have to do things then they won't do it. You know if err if as a child if something hurt or they didn't want to do it, erm then if they are given the right not to then they won't, and if that's sort of the way they have been bought up perhaps...

There's another thing that came up, that was erm they kind of expect all their family, because they're old it was like elderly people I was sort of ..., and they kind of expect all their family to look after them and run around after them, and that we are outsiders and we shouldn't be there and it should be their family that should be looking after them and we are not helping, just go away…

It wasn't just Asian people that I came across, like black, err there was a black gentleman that was terrible, he just wouldn't do anything. It was like passive movements when erm when he's not using. He had a muscle strain, when he wasn't using his muscles and you could get his arm way past anywhere, erm but the minute he tried to do it himself, I mean obviously there was some pain because he'd hurt himself, but he could have got a lot further than erm on his own than he did, he kind of moved it just a little tiny bit and he was like oh it hurts so much. When I mean it sounds harsh, but he obviously could have gone further.

[X]

Yeah, lots of issues it's not a simple, nothing is simple, it's very difficult. The last question I've got really is, **are you aware of any formal mechanisms such as handbooks, videos which might help you to work in a cultured diverse environment**. Was there anything out there that you felt is beneficial anything that you think might be helpful to get round some of these issues, or anything that we as a school you know, what did you find?

Nothing…..

(( ))

Yeah yeah…

And there's that advocate thing that you mentioned that… I think would be a very useful for the situation I saw…

Just think it's strange that I haven't seen any of it in practice, you hear about leaflets, but they just don't seem to be available, cause I haven't seen anything…

Yeah yeah…

But then this is, it wasn't one that had been sent to the department it was one they made up themselves, and had translated, so that that was for the leaflet thing, but that was it, that was all, that was their way of…..

You'd of thought they would have sort of a chart of the basic words that you need to get across and have a chart of what they are in different languages…so they know how to say them phonetically so if they can't read or write…

Good idea isn't it…..

Or have a tape, so that they can listen to…

It's funny, it must be fifteen years, that's showing my age, now that I was working at the general, used to be the General hospital, its now the Children's hospital, and we had a diverse group of patients coming in again, and I remember what I had to do was to ask patients to give me the names of hot, cold, pain you know, tender, things like and I remember I wrote them down in English and in Urdu or whatever it was so that we both had, you know a list of words that we could use, but things haven't moved on very much has it …

No, because…

Please, thank you, can I help, you know those are basic words that we would find, all of us would find useful…

.... learn to use facial expressions..., non-verbal communication, I think that's ... and be clear not like …., try and be definite in your movements and what you want them to do so then there's no, they might get confused about one word and ...

I'm hoping the second year, you'll probably feel a bit more equipped, because you have another session on clinical studies and we will look at some of these issues again, and this is why we explore them now in the first year, because this will help me to build…

[X]

I hear it time and time again. Feed it back alright I'm hoping there will be the opportunity just like there is here, we only had one lesson probably on culture and something you know before you went out there. Clinical Sciences much longer and it will give you more opportunity, likewise feedback on clinical sciences because for the next group coming along you know it will be helpful. [X]

Well its good to (get the) basics before you do the clinical. I think once you've done the clinical you then realise how much you have to do yourself, you need to know methodologies…

[X]

Ironically I've put that one of my strengths was communication because in general urm I get on very well with my patients and sort of can put them at ease, and you know if I don't, if I don't know what I am going to do with them I can get on with them. So I think that's why it affected me so much that I couldn't communicate with this woman, that I felt that that was a weakness then…

Its funny how strength suddenly becomes a weakness isn't it…

Yeah I think that's why it affected me so much…

I think there's also professionalism as in communication, because I found myself being…

Is this a strength, how we talking?

No weakness wise, so because these, because I'm my personality I got like a caring personality I like to talk a lot to people and I think with my weakness would be not being professional enough with the patients and being too over familiar with them. And there is a certain extent to which you can chat you know but you need to get (( )), you've got to have a professional limit because otherwise they are not going to respect you and do what you want them to do…

Okay, I think what Lecturer X wanted us to do is see whether there were any common trends, yes so if I can ask you all to read that very, I don't know how much time we've got, your strengths first and then we'll see whether there is a common pattern, in these trends, so let's hear your strengths as we go round the table…

[X]

Communication, assessment yeah interesting, strengths?

Again, very good?

Erm I actually interpreted it as being strengths and weaknesses of the placement…

Yeah I did that as well…

Okay, did you all do that, in the main?

Yeah…

Okay go on…

I did for the opportunities…

Let's have some more then, let's have a look at the placements, variety you said then, shall we include variety yeah…

Yeah patients in different ages and cultures…

Yeah…

I just had the strength of the placement was that, because it was outpatients I got to put electrodes clinical (()) the whole lot into one and erm a weakness of it though was that the transition between that theory and practice was so big.

[X]

I wish I could write that all down, I can play my tape back though. Do you want, who wants to feed back, shall we have someone other than me feed back. Cause so far we have summarised that communication, assessment and enthusiasm, come on lets have a volunteer, who's going to volunteer…?

To do what?

To feed back to the group…

Go on then X…

Leturer X wants everyone to feed back from the group. Right so generally you can talk about what we were talking about as a group, I think that's quite useful for the others that we concentrated on talking generally about problems with working with diverse communities, and the sort of things, whatever you want to say about that, it's fine by me, and then generally what we are saying now about the common, [X] the common, our strengths our communication, assessment erm the transition, weaknesses a lot of people think the same, weaknesses are the transition between theory and practice, I think a lot of people were nodding…

Definitely…

[X]

Well thank you ever so much, I do hope, I know this information is going to be useful and I will feed back to you right

[X]

Thanks very much, great!

APPENDIX 10

Clinical Studies Module

CLINICAL STUDIES MODULE **Year 2** **Semester 2**

Code: 02 06617

Credit Value: 10

Honours Weight: 4%

Contact Hours: 50

Independent Study Hours: 50

Closed Module

Objective

To develop the student's ability to reflect on the practice of physiotherapy in the current health care context.

Learning Outcomes

The outcomes of this module will be enhanced ability to:-

1. reflect on learning in clinical modules
2. contribute in the cycles of quality and audit
3. explore issues of race and culture in the context of practice
4. make ethical decisions in the context of practice
5. follow concepts of task delegation and supervision.

Teaching and Learning Strategy

This module will be interactive in response to student generated issues relevant to the anticipated outcomes.

Outline Syllabus

- Reflection on practice and portfolio update
- Clinical audit
- Health care in a multicultural society
- Ethics
- Role of physiotherapy assistants

65

Assessment

Clinical Studies Assignment Semester 2: Week 12 (resit 2:17)

The student will be required to submit a learning contract negotiated within a clinical module accompanied by an experiential learning analysis of 1000 - 1500 words. This assessment, which carries 4% honours weighting, must be passed for award of modular credits. Criteria for marking are included in Appendix 1.

Core Texts

CSP (1990) *Standards of Physiotherapy Practice.* London: CSP.

CSP (1996) *Standards for Continuing Professional Development* London: CSP.

French S. (1992) *Physiotherapy: A psychosocial approach* Oxford: Butterworth Heinemann.

Mason J. K. & McCall-Smith R. A. (1995) *Law and Medical Ethics* London: Butterworths.

Pugh R. (1996) *Effective Language in Health and Social Work* London: Chapman & Hall.

APPENDIX 11

Schedule of teaching sessions in cultural sensitivity

Session 1 (Semester week 2.4)

Session Objectives:

Students should:

- *Be familiar with the objectives of the module*
- *Have increased awareness of the minority groups in Birmingham*
- *Have explored the issues that have arisen in the clinical situation in relation to minority groups*
- *Have identified areas of personal development which may contribute to developing effective health care for minority groups*

Review of context:

Previous sessions included: Introduction to race, culture, ethnicity (Year 1)

****

Session 2 (Semester week 2.5)

Learning Outcomes:

Students will have

- *Examined eurocentric perspective on culture*
- *Increased awareness of the cultural groups in Birmingham*

Context:

Previous week – defined culture, explored experiences with different cultural groups and the issues which arose, discussed some culturally sensitive issues.

****

Session 3 (Semester week 2.6)

Session Objectives:

Students should:

- *Become familiar with the culture/lifestyle an individual or group of individuals from an identified minority group (through visits)*
- *Have explored the issues raised as listed on 'the activity sheet' with respect to the identified minority group*
- *Compile a report of the issues arising out of the exploratory work outlined above*

Review of context:

Previous sessions included: Introduction to race, culture, ethnicity, prejudice, discrimination, minority groups in Birmingham, intercultural communication, discussions on cultural sensitivity.

****

Session 4 (Semester week 2.7)

Session Objectives:

Students will have opportunity to visit minority groups and project work

Review of context:

Previous sessions included: Introduction to cultural sensitivity, feed back on SHS research, multicultural communication, minority groups in Birmingham, intercultural communication, discussions on cultural sensitivity.

****

Session 5 (Semester week 2.10)

Learning Outcomes/Objectives:

Students will

- *Present findings from investigations of minority groups*
- *Have increased awareness of the CSP's stance on equal opportunity issues*

Context:

Previous topics – defined culture, explored experiences with different cultural groups and the issues which arose, discussed some culturally sensitive issues, multicultural communication, exploration of minority groups

****

Session 6 (Semester week 2.11)

Learning Outcomes/Objectives:

Outside speaker

(Interpreters and Translators – Multi-faith Facilitator)

Session 7 (Semester week 2.11)

Session Objectives:

Presentation of projects

Module evaluation

Review of context

Previous topics – defined culture, explored experiences with different cultural groups and the issues which arose, discussed some culturally sensitive issues, multicultural communication, exploration of minority groups

APPENDIX 12

Feedback form including examples of clinical experience with minority groups

UNIVERSITY OF BIRMINGHAM

SCHOOL OF HEALTH SCIENCES – PHYSIOTHERAPY

CLINICAL STUDIES – CULTURAL SENSITIVITY

Clinical Experience with Minority Groups

Identify the individual/situation by culture/ethnicity (no personal names)

Identify the medical request or situation

Outline personal involvement

Identify the challenge

Give the resources that were available to you to deal with the issue

Are you aware of any other resources?

Impression of overall management of the individual

Remaining concerns

Examples of Clinical experience with minority groups

Studentt	Culture/ethnicity	Medical condition	Challenge	Management and remaining concerns
1.	Welsh speaking patient No resources identified	Stroke	Although student spoke welsh patient was dyslexic, able to assist patient personally	Future care after leaving placement
2.	Punjabi speaking patient	Stroke	Patient had spoke no English and I had no experience with the language	Sometimes patient missed out on treatment, no interpreter
3.	Italian speaking patient Resource CE, relatives, treatment protocols	Dementia	No English	Difficult explaining to relatives the need for consent
4.	Elderly Muslim Resources - CE	RA		Compromise to pray kneeling at every other meeting after discussion with family
5.	Punjabi speaking? patient Resources – other physios, gestures, interpreter	Respiratory problem	Unable to pronounce her name initially	Patient went away happy
6.	Punjabi speaking patient Resources – family,	‘disabled’ pt in the community		No remaining concerns

Studentt	Culture/ethnicity	Medical condition	Challenge	Management and remaining concerns
	professional interpreter			
7.	Afro-Caribbean Family and CE	Stroke	Difficulty understanding each other, pt had strong accent	Whether treatment was appropriate, whether there was mutual understanding
8.	Blind Resources – physio	CVA	At first it was difficult as pt was reluctant to move	Learned to use hands in direction of movement rather than just instructions, learnt a lot from the patient
9.	Non-English speaking. Resources – Translators, use of family	To teach breathing exercises	Not able to speak English, used actions	Managed deep breathing very well
10.	Welsh speaking Resources – other physio, welsh dictionary, language chart made	Stroke with dysphasia	Couldn't directly communicate, I had to go through other physio	The hospital I was at was close to Wales but very few of the physios spoke Welsh
11.	Asian male Resources – CE	outpatient	Could not understand the gentleman	Eventually understood by making questions simpler and showing form to patient with questions on
12.	Asian gentleman – Resources – interpreters, family, SALT language aids, IST	postoperative	Trying to make pt understand	Treating when there is no translator available
13.	Asian patient	Stroke	Did not speak English	Very hard to motivate pts when

Studentt	Culture/ethnicity	Medical condition	Challenge	Management and remaining concerns
	Resources – translators			cannot explain the benefits to them
14.	Asian lady Resources – CE	Stiff neck and upper back	Lady stripped completely revealing a belt with a dagger	Shocked, would have appreciated a warning from educator
15.	Elderly Asian lady Resources – translator	Stroke	Non-English speaker, cultural challenges	Pt lacked motivation for sessions, family were fully caring. Was it a waste of our time?
16.	12 year old Muslim Resource – no	Surgery for ruptured quads	Against her religion to expose arm in public gym	Compromised not sure if I could have handled situation any differently or better
17.	Asian male Resources – family?	TKR	Culture difference, family protectiveness rather than support, very unwilling to participate and family not encouraging	When he went home …he didn't do anything himself and stayed in bed, knee flexion decreased approx 20 degrees

APPENDIX 13

Schedule of visits to community groups and example of student experience

SCHOOL OF HEALTH SCIENCES – PHYSIOTHERAPY

CLINICAL STUDIES MODULE – CULTURAL SENSITIVITY

MINORITY GROUPS IN BIRMINGHAM

The South X Specialist Community Trust has kindly arranged the following visits to:

Asian Women's Centre (5 students)

1

2

3

4

5

Elderly Day Centre (10 students)

1	6
2	7
3	8
4	9
5	10

St X Rehab Centre (4 students)

1

2

3

4

X Refugee Centre (5 students)

1

2

3

4

5

Please sign **once** under any of the places you might be interested in visiting.

Places will be offered on a 'first come, first served' basis. It would be helpful if you have the use of a car but all areas are easily reached by public transport. Further information on how to get to your destinations is outlined below.

All students are expected to continue with the work set on minority groups during the timetabled sessions.

Example from students' experience

To widen my awareness of minority groups in X and to address cultural sensitivity I visited X, a day care centre to the local elderly Asian community.

The founder of the centre, X, provided a fountain of information regarding his clients and the history of the centre.

The centre is exclusively for Asians and is run by voluntary carers. In order to keep financially secure the centre operates a 'meals on wheels' facility, which provides the local elderly with freshly cooked food akin to their culture. The centre has a mini-bus and picks up clients on their chosen regular attendance days. Both men and women are welcome and sit in identified areas with their same gender. This respects those who follow the Muslim faith. However, the attendees vary in religion and along with Muslims, come Hindus and Sikhs. To accommodate this, the centre has specified prayer rooms and menus for different faiths, should people want to pray.

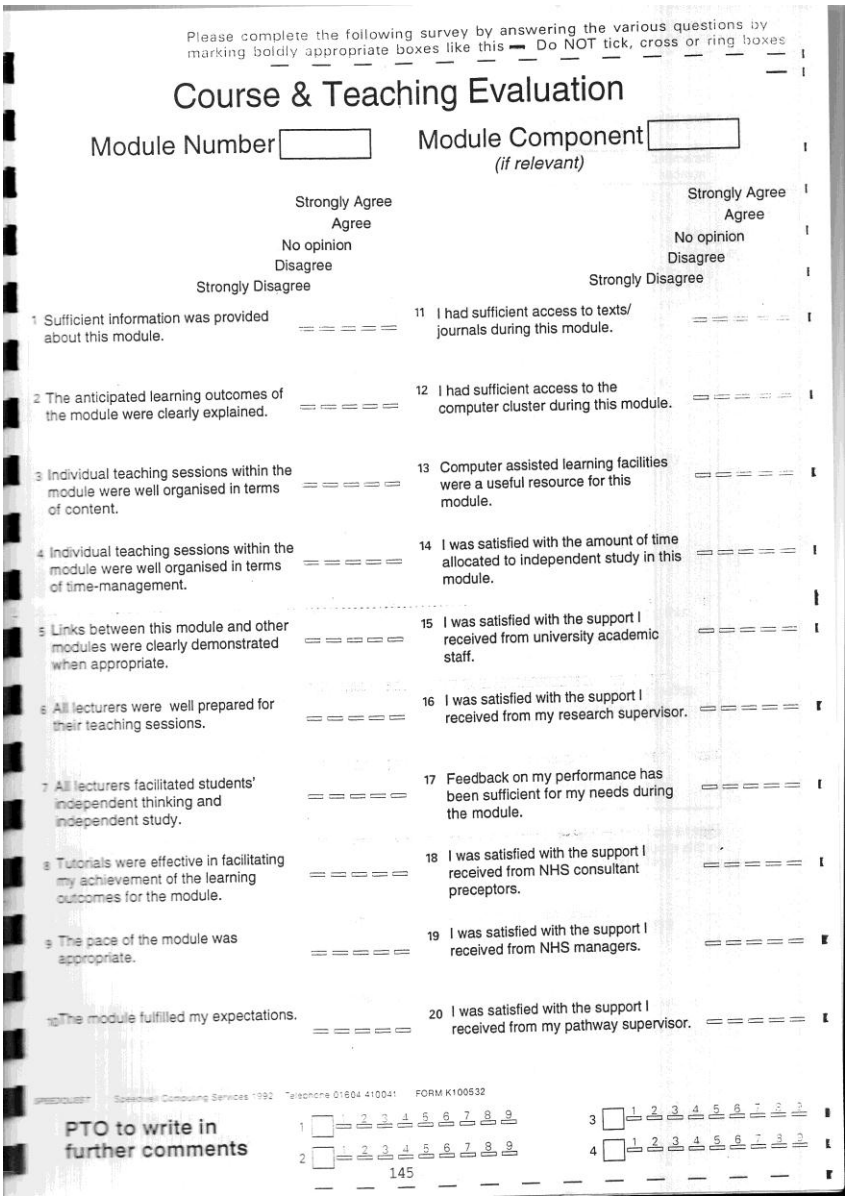
The diversity of origins of the clients also means they may well speak different languages. This is largely overcome by using Punjabi; a common dialect taught to all Asian communities.

Due to religious constraints the females also have an allocated dining room apart from the males. When personal care is required, where possible, female carers deal with the ladies and vice versa.

The centre has a friendly atmosphere and it was clear that for these elderly, coming from a very different cultural background, fully appreciated this 'haven'. Here they were surrounded by people they could identify with and generally be in an environment which was familiar and safe. These feelings of safety and familiarity are priceless for the often anxious and vulnerable elderly. The demand for such centres is highlighted by its over-subscription.

APPENDIX 14

Course and teaching evaluation form



Please complete the following survey by answering the various questions by marking boldly appropriate boxes like this ▬ Do NOT tick, cross or ring boxes

Course & Teaching Evaluation

Module Number ☐ Module Component ☐ *(if relevant)*

Strongly Agree / Agree / No opinion / Disagree / Strongly Disagree

1 Sufficient information was provided about this module.

2 The anticipated learning outcomes of the module were clearly explained.

3 Individual teaching sessions within the module were well organised in terms of content.

4 Individual teaching sessions within the module were well organised in terms of time-management.

5 Links between this module and other modules were clearly demonstrated when appropriate.

6 All lecturers were well prepared for their teaching sessions.

7 All lecturers facilitated students' independent thinking and independent study.

8 Tutorials were effective in facilitating my achievement of the learning outcomes for the module.

9 The pace of the module was appropriate.

10 The module fulfilled my expectations.

11 I had sufficient access to texts/ journals during this module.

12 I had sufficient access to the computer cluster during this module.

13 Computer assisted learning facilities were a useful resource for this module.

14 I was satisfied with the amount of time allocated to independent study in this module.

15 I was satisfied with the support I received from university academic staff.

16 I was satisfied with the support I received from my research supervisor.

17 Feedback on my performance has been sufficient for my needs during the module.

18 I was satisfied with the support I received from NHS consultant preceptors.

19 I was satisfied with the support I received from NHS managers.

20 I was satisfied with the support I received from my pathway supervisor.

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PTO to write in further comments

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

3 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

2 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

4 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

145

APPENDIX 15

Personal reflections on teaching in the Clinical Studies module

APPENDIX 16

Repertory grid template and list of instruction

THE GRID (CULTURAL COMPETENCE)

	ELEMENTS						
CONSTRUCTS	**1**	**2**	**3**	**4**	**5***	**6**	**CONSTRUCTS**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Grid instructions

A formal way of demonstrating the mathematical relationships between specific constructs (adjectives) and the elements (people) construed.

(I am interested in how you construe **CULTURAL COMPETENCE**)

Everyone should have: **a grid, 7 cards and a list of these instructions** on their tables.

1 Think of approximately 6 people (practitioners) including yourself, 3 of whom you regard as culturally competent and 3 who are not culturally competent.

2 Write down each of the 6 names (anonymised) on the 6 cards. Leave the 7th card; you will be using it later.

3 Take three of the cards.

4 Ask yourself, 'In relation to cultural competence, is there any important way in which two of these people are similar and thereby different to the third?' i.e. the adjective which describes two of these people is an opposite of the adjective which describes the third.

Write down this adjective on the 7th piece of paper as number 1.

5 Repeat this exercise with 3 different cards until you have approximately 10 adjectives (constructs).

Make sure the adjectives are numbered 1 to 10.

6 Number the people on the cards from 1 to 6.

7 Place the cards in order.

8 Write in all 10 constructs on your grid.

9 Take card number 1 and give it a rating on the first construct on your list of 10, on a scale of 1-7 where, 1 = **not** at all culturally competent, and 7 = clearly culturally competent.

Keep card number 1 and continue to rate it on all of the 10 constructs on your grid.

10 Take card number 2 and repeat the exercise in 9 above.

11 Continue to do this for all of your 6 elements.

12 Please make sure that you place an asterisk in the element box which denotes you, **and** that you put in your full name at the bottom of the page. This will be removed at a later date. All the information given will remain confidential.

APPENDIX 17

Related t test and Spearman Rho correlation

Paired Samples Test

			Paired Difference					
	Mean	Std Deviation	Std. Error Mean	95% Confidence Interval of Difference		t	df	Sig. (2 tailed)
				Lower	Upper			
Pair 1 Clinical-Cultural	-9.89	9.88	1.54	-13.01	-6.77006	-6.40	40	0.000

Correlation of clinical competence and cultural competence

			Clinical competence	Cultural competence
Spearman's Rho	Clinical competence	Correlation coefficient	1.000	.453(**)
		Sig. (2-tailed)		.003
		N	41	41
	Cultural competence	Correlation coefficient	.453(**)	1.000
		Sig. (2-tailed)	.003	
		N	41	41

** Correlation is significant at the 0.01 level (2-tailed)